EVERGREEN PEDIATRICS, INC.

4205 San Felipe Road, Suite 110
San Jose, CA 95135
408-238-8303

Patient Registration

PATIENT INFORMATION

Last Name	First	Male Female
Street Address		DOB:
City	State	ZIP
Home Tel:	E-mail:	
Mother's Name	SSN:	DOB:
Address:		Tel:
Employer Name & Address:		Cell:
Father's Name	SSN:	DOB:
Address:		Tel:
Employer Name & Address:		Cell:

GUARDIAN (ONLY REQUIRED IF YOU ARE NOT THE PARENT)

Name:	Cell:	SSN:
Address:		Tel:
Employer Name & Address:		

INSURANCE:

Company Name:	Tel:
Group ID & Primary Member ID:	

HOW DID YOU HEAR ABOUT US:

News Paper:	Internet:
Referred by :	
Other Sources :	

DISCLAIMER AND SIGNATURE

I authorize treatment of the person named above and agree to pay all fees and charges for treatment that is not covered by the primary insurance carrier. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writhing. Charges shown by statements are agreed to be corrected and reasonable unless protested in writing within ten days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the dependency of claims thereon, and all proceeds of insurance are assigned to Evergreen Pediatrics, Inc., where applicable, but without their assuming responsibility for the collection thereof. (A copy of this agreement is as valid as the original.)

Signature	Date