Colony Pediatric - **Quntao Yu, MD, FAAP**
4427 Highway 6, Suite J, Sugar Land, TX 77478 Tel: 281-565-8188

MRN: _____ **新病人资料 New Patient Information** **过敏史 ALLERGY: _____**

PATIENT

病人姓名: _____ _____ _____社会安全号_____ 生日: ___/____/_____
Patient's Name 姓 Last 名 First Middle Social Sec. No. Birth Date mm dd yy yy
性 别 : 男 女 民 族:_____出生地: 国家_____医院_____ 妇产科医生: _____ 城市: _____
Sex: M F Race: Place of Birth Hospital Obstetrician City
地 址 : _____
Address 号 No. 街 Street 门牌 Apt. 城市 City 州 State 邮区号 Zip
E-Mail Address:

介绍人 Patient Refered by _____ Phone # _____

PARENT / GUARDIAN ID #

	手机 Cell Ph	工作电话 Work Ph	住家电话 Home Ph
父亲 Father			
母亲 Mother			
监护人 Guardian			

父亲姓名 : _____ 生日: _____/_____/_____社会安全号 _____
Father's Name DOB Social Sec. No.
父亲雇主 : _____ 驾照号 _____
Father's Employer Driver's Lic .#
母亲姓名 : _____ 生日: _____/_____/_____社会安全号 _____
Mother's Name DOB Social Sec. No.
母亲雇主 : _____ 驾照号 _____
Mother's Employer Driver's Lic .#
监护人姓名 : _____ 生日: ___/___/___社会安全号 _____ 驾照号 _____
Legal Guardian's Name (If other than parents) DOB Social Security No. Driver's Lic. #
监护人雇主 : _____ 驾照号 _____
Legal Guardian's Employer Driver's Lic #

INSURANCE

Insurance: _____ HMO / PPO / POS / Other _____Policy#:_____

Policy Holder: _____ DOB: _____ SSN: _____

Relationship to Patient: Father/Mother/Guardian/_____

2nd. Insurance(Circle one): No If Yes, please fill in: Ins. Name_____

Policy Holder:_____ DOB: _____ SSN:____-____-_____ Effec No

Relationship to Patient: Father/Mother/Guardian/_____ Do you have Medicaid: Y N

Please present current valid Insurance(s)/Medicaid eligibility card to front desk for verification.

SIBLINGS

Total Number of Children:_____ Names: (First and Last and Date of birth)

1.) _____/____/_____2.) _____/_____/_____

3.) _____/____/_____4.) _____/_____/____

In Case of Emergency Notify: Name _____Relationship:_____ Phone :_____

Please Note: INITIAL VISIT AND ALL ROUTINE OFFICE VISIT MUST BE PAID AT TIME OF SERVICE
ALL MINORS MUST BE ACCOMPANIED BY AN ADULT

I HAVE READ AND UNDERSTOOD THE NOTICE OF PRIVACY PRACTICES (HIPPA) OF COLONY PEDIATRIC. I HEREBY, VOLUNTARILY CONSENT AND AUTHORIZE DR. QUNTAO YU, HIS ASSOCIATES, ASSISTANTS, OR OTHER RELATED HEALTHCARE PROVIDERS TO PERFORM DIAGNOSIS, TREATMENT/VACCINATION BELIEVED TO BE NECESSARY ON MY CHILD AS LONG AS MY CHILD IS A PATIENT OF DR. YU'S, OR UNTIL I WITHDRAW MY CONSENT. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR SPECIALIST REFERRAL, PROCESS THIS CLAIM, AND REQUEST PAYMENT OF INSURANCE AND/OR MEDICAID BENEFITS TO QUNTAO YU, MD. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR PROMPT PAYMENT OF ALL BALANCES WHETHER OR NOT AN INSURANCE CLAIM HAS OR WILL BE FILED.

Legal Guardian Signature:_____ Relation: _____Date:_____/_____/_____