Colony Pediatric - Quntao Yu, MD, FAAP
4427 Highway 6, Suite J, Sugar Land, TX 77478

MRN: _____ **New Patient Information** **Medication ALLERGY: _____**

PATIENT

Patient's Name _____ _____ _____ _____ Birth Date: ___/____/_____
Last First Middle Social Sec. No. mm dd yy yy

Sex: M F Race: _____ _____ _____ _____
Place of Birth: Hospital City Obstetrician

Address: _____
Street No. Apt. # City State Zip

E-Mail Address: **Pharmacy #** **Fax #**

****Patient Referred by** _____ Phone # _____

PARENT / GUARDIAN ID #

	Cell Phone No.	Work Phone No.	**Home Phone No.**
Father			
Mother			

Father's Name: _____ DOB: ____/_____/_____

Employer: _____ DL# _____SSN:_____

Mother's Name: _____ DOB: _____/_____/_____

Employer: _____ DL# _____SSN:_____

Legal Guardian's Name: _____ DOB:___/___/_____ Phone # _____
(If other than parents)

Employer: _____ Work # _____ DL# _____SSN:_____

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: ____-____-_____ Effective Date:

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: _____/_____/_____