



Welcome to our practice!

Frederick A. Lauppe, M.D.
Sandra A. Hollenberg, M.D.
Pramila Agrawal, M.D.
Carrie Knoll, M.D.
James Warren, M.D.
Ericka Hong, M.D.

**We strive to make each visit pleasant and comfortable for you child/adolescent.
Please completely fill out this form.**

Patient Account:

Date :

PATIENT

Name: _____ Gender: _____

Date of birth: _____ Home Phone: _____

Address: _____ Apt# _____

City, State, Zip code: _____

Language(s) you speak at home: _____

SIBLINGS

Name : _____ Name : _____

Date of Birth: _____ Gender : _____ Date of Birth: _____ Gender: _____

Name : _____ Name : _____

Date of Birth: _____ Gender : _____ Date of Birth: _____ Gender: _____

Name : _____ Name : _____

Date of Birth: _____ Gender : _____ Date of Birth: _____ Gender: _____

AUTHORIZATION AND RELEASE

I hereby authorize medical or surgical treatment by the doctor in person or provider under his/her supervision. I certify that all information given by me is correct.

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my dependent's insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my dependent's insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I hereby authorize medical payment and/or medical information to be released directly to Frederick A. Lauppe, Jr., M.D., Sandra A. Hollenberg, M.D., Pramila Agrawal, M.D., Carrie Knoll, M.D., James T. Warren, M.D., and Ericka Hong, M.D. at 250 W. Bonita Ave., Suite 200, Pomona, CA, 91767.

Responsible Party Signature: _____ Date: _____

Patient Name:

Date of Birth:

Account:

MOTHER

Name: _____ Please circle: Mother, Stepmother, or Guardian

Date of Birth: _____ Email Address: _____

Home Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Employer city/state: _____ Work Phone: _____

FATHER

Name: _____ Please circle: Father, Stepfather, or Guardian

Date of Birth: _____ Email Address: _____

Home Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Employer city/state: _____ Work Phone: _____

Parent's marital status: Single Married Divorced Widowed Separated

ALTERNATE CONTACTS IF UNABLE TO REACH YOU BY PHONE OR MAIL FOR ANY REASON

Name: _____ Relationship to child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to child: _____

Address: _____ Phone #: _____

Name: _____ Relationship to child: _____

Address: _____ Phone #: _____

PATIENT'S PRIMARY INSURANCE

Insured's Name: _____ Insured's DOB: _____

Insurance Company: _____

Subscriber Member #: _____ Group #: _____

PATIENT'S SECONDARY INSURANCE

Insured's Name: _____ Insured's DOB: _____

Insurance Company: _____

Subscriber Member #: _____ Group #: _____