Freyja Clinic
Pediatrics - Dr Aarti Nasta & DR Carmela Yarlagadda

570 Price Ave♦ Suite 100♦ Redwood City ♦ California ♦ 94063
Tel: 650.302.8337 ♦ Fax: 650.701.1886 ♦ Email: www.bayareafps.com

Patient's Name: _____
Last Name First Name MI

Patient's Date of Birth: _____/_____/_____ Patient's Sex: _____M ____F

Patient's Home Address: _____

_____

Patient Lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Mother's Information:	***Father's Information:***
Name:	Name:
DOB:	DOB:
SSN:	SSN:
Address:	Address:
City:	City:
State: Zip:	State: Zip:
Employer:	Employer:
Occupation:	Occupation:
Daytime Phone:	Daytime Phone:
Cell Phone:	Cell Phone:
Email:	Email:

As the parent/legal guardian of said minor, I understand that sending/receiving emails is not a secure method of communication but I approve of using this method of communication with regards to my minor.

Who is insurance policy under: ☐ Mother ☐ Father ☐ Other: _____

Name of Insurance: _____
(Copy of insurance card must be given to staff for copy to be filed in patient chart)

Emergency Contact Information:

Name: _____ Relationship to patient: _____

Phone Number(s): _____

CLAIMS AND INSURANCE STATEMENT

I am aware I must present my current insurance card for each visit so the office can bill my insurance company for medical services rendered. I understand that presentation of my insurance card is not a guarantee of payment by my insurance carrier. Claims are subject to current eligibility and benefit review.

I, THEREFORE, AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES RECEIVED REGARDLESS OF INSURANCE ARRANGEMENTS.

I authorize the release of medical records or other information necessary to process claims and I authorize payment of medical benefits to this medical office.

I AGREE THAT CO-PAYMENTS, DEDUCTIBLES AND PAYMENT FOR NON-COVERED SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED.

PARENT'S SIGNATURE: _____ ***DATE:*** _____