Pachie Chan M.D

Patient Registration Form

Welcome to Our Practice!

PATIENT INFORMATION

Name: _____ Patient ID#: _____ Sex: [ ]M [ ]F
Address: _____ Date of Birth:_____
City: _____State: _____ Zip: _____ Social Security #: _____
Phone: _____ Nickname of Child:_____
Father/ Guardian Name: _____ Race; [ ] Asian [ ] Black or African American
Cell Phone: _____ [ ] White [ ] Hispanic [ ] Other _____
Mother/Guardian Name: _____ Child Lives With: [ ] Mother [ ] Father [ ] Both
Cell Phone: _____ [ ] Other _____

RESPONSIBLE PARTY (Who pays the Childs Medical Bills)

Relation to Patient:_____
Name: _____ Employer: _____
Address: _____ Phone: _____
City, State, & Zip: _____ Date of Birth: _____
Social Security#: _____

PRIMARY INSURANCE (Must complete in its entirety in order for us to file with your insurance.)

Name of Insured:_____ Relation to Patient: _____
Name of Insurance Company:_____ Insured SS#: _____
Insurance Phone #: _____ Policy Group #: _____
Insured Employer: _____ Insured Date of Birth: _____

SECONDARY INSURANCE (if applicable)

Name of Insured:_____ Relation to Patient: _____
Name of Insurance Company:_____ Insured SS#: _____
Insurance Phone #: _____ Policy Group #: _____
Insured Employer: _____ Insured Date of Birth: _____

PHARMACY INFORMATION

Pharmacy: _____ Pharmacy Phone # : _____
Pharmacy Location:

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for
the purpose of evaluations and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____ _____
Patient or Guardian Signature Relationship to Patient Date

PACHIE CHAN M.D. PLLC

PEDIATRIC QUESTIONNAIRE

Above Age 5

Patient Name: _____Age: _____ DOB: _____

Reason for today's visit: _____

MEDICATIONS

Allergic to Medications

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Current Medications:

Name: _____ Dose: _____ How is it taken: _____

Name: _____ Dose: _____ How is it taken: _____

Name: _____ Dose: _____ How is it taken: _____

Past Medical History

	Yes	NO	Date		Yes	NO	Date
Allergies	_____	_____	_____	Scarlet Fever	_____	_____	_____
Asthma	_____	_____	_____	Whooping Cough	_____	_____	_____
Bed Wetting	_____	_____	_____	Sickle Cell	_____	_____	_____
Diabetes	_____	_____	_____	Chicken Pox	_____	_____	_____
Seizures	_____	_____	_____	Obestiy	_____	_____	_____

Surgical History

Type:_____ Year: _____

Type:_____ Year: _____

Family History

	Mother's Side	Fathers Side		Mother's Side	Father's Side
Allergies	_____	_____	Cancer	_____	_____
Asthma	_____	_____	Diabetes	_____	_____
Heart Disease	_____	_____	Seizures	_____	_____
Obesity	_____	_____	Sickle Cell	_____	_____

Social History

Household Members: _____ _____Mother _____ Father _____Brother(s) _____ Sister(s)___ Other_____

Pets in the home? _____ Yes ____ NO Smoking in the home? _____Yes _____No

Vaccine History

Please provide a copy of your child's vaccine record.

PACHIE CHAN M.D.
DELIGATION OF CONSENT

Name of Patient: _____ D.O.B. _____

I hereby authorize (when I am Unavailable to give consent) the following Individual(s)

_____	_____
Name of Person	Relationship to Child
_____	_____
Name of Person	Relationship to Child
_____	_____
Name of Person	Relationship to Child
_____	_____
Name of Person	Relationship to Child

To consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Texas. This consent includes, but is not limited to , medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

_____	_____	_____
Signature of Parent/Guardian	Relation to Patient	Date

_____
Witness