WINDHAVEN PEDIATRICS
Monica Hererra, M.D.
Danny Kim, M.D.
Lily Han, M.D.

PATIENT INFORMATION

TODAY'S DATE:________________________

Child resides with: ( ) Parents ( ) Mother ( ) Father ( ) Other **Referred By:___________________________________**

Last Name_____________________________ First Name_________________________________ Date of Birth________________ Male / Female

Address____ City______________________ State_______ Zip Code_______

Home Phone (___)____________________________ Birthplace_______________________________Race_______________________

Emergency Contact____Phone__________________________________

PATIENT/SIBLING INFORMATION

Last Name_____________________________ First Name_________________________________ Date of Birth____________________ Male / Female
Last Name_____________________________ First Name_________________________________ Date of Birth____________________ Male / Female
Last Name_____________________________ First Name_________________________________ Date of Birth____________________ Male / Female

PARENT INFORMATION

Mother's Name____ Work Phone (____)_________________ Cell (____)___________________________

Address(if different)____ Date of Birth____

Employer____ **Email Address** ____

Social Security#_________________________________ Drivers License # ______________________________ State___________________________

Father's Name____ Work Phone (____)_________________ Cell (____)___________________________

Address(if different)____ Date of Birth____

Employer____ **Email Address** ____

Social Security#_________________________________ Drivers License # _______________________________ State__________________________

INSURANCE INFORMATION

Primary Insurance____

Insurance Address____ City _______________________State____________ Zip_________

Insurance Phone#________________________________ Policy/Certificate#_______________________________ Group/Acct#__________________

Insured's/Policy Holder's Name____ Date of Birth__________________________________

Please present your insurance card to the receptionist so a copy may be made. Thank you.

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to the attending physician. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by the said insurance. I hereby authorize said assigned to release all information that might be necessary to secure payment.

Parent/Guardian____ Date___________________________________