



Prasad Pediatrics

Patient Information Update Form

****Confidential****

****THIS FORM NEEDS TO BE FILLED OUT IN IT'S ENTIRETY****

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Telephone: _____ Work Telephone: _____
Circle One: Home Cell (optional)

Parent's Name: _____ DOB: _____ Cell Phone #: _____

Parent's Name: _____ DOB: _____ Cell Phone #: _____

Email Address for Patient Portal: _____

Emergency Contact: _____ **Phone #:** _____

Relationship to Patient: _____

Driver's License/Government Issued ID: **(This is mandatory for identification and billing purposes)**

Driver's License # _____ Expiration Date: _____ (copy in chart)

Preferred Language: _____ **Pharmacy Name and Phone:** _____

Insurance Information: (Insurance card copy in chart)

Name of Insurance: _____

Subscriber Name: _____ Relationship to Patient: _____

ID#: _____ Group # _____

Do you have secondary insurance? (Please Circle): **YES** **NO**

If you circled yes, fill out the below section:

Name of (Secondary) Insurance: _____ (Insurance card copy in chart)

Subscriber Name: _____ Relationship to Patient: _____

ID#: _____ Group # _____



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2026 Patient Registration Form

****Confidential****

I hereby acknowledge that certain fees may be ascertained by the doctor's staff for any requested letters, medical records, school notes, or physical forms without a visit, and immunization records (including transfer of records). Payment must be rendered at time of service.

Your copay **MUST** be paid at time of service. NO EXCEPTIONS

If my insurance information is incorrect or terminated at the time of my visit, I will be responsible for the full amount not covered.

I AGREE TO THE ABOVE FEES AND COPAYS: _____

(Sign and Date here)

I hereby authorize direct payment of medical benefits to Prasad Pediatrics. I understand that I am financially responsible for any balance not covered by my insurance. If I have any outstanding balances with this office (**including deductibles and increases in co-pay amounts**) and they are not paid within a **fifteen day (15)** time period, I will be responsible for an additional **\$10.00** fee on top of the amount due and owing. If this account has to go to collections, I will be responsible for the collection agencies fees and costs. I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf.

Parent/Guardian Name (Print): _____

(If patient is older than 18, please print patient name above)

Parent/Guardian Name (Signed): _____

(If patient is older than 18, please sign patient name above)

Date: _____



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IMPORTANT NOTE TO PATIENTS

PLEASE READ AND SIGN

EFFECTIVE IMMEDIATELY:

If you bring in a child and you are NOT the parent, in order to be seen, you will need to provide us with a note from the parent stating that you (Ex: aunt, grandmother, grandfather, friend) are able to bring the child to this office and able to discuss with the doctor any medical issues or concerns.

If we do not receive a letter from the child's parent, the child will not be able to be seen.

Thank you

Please list one person who would be able to bring your child to this office if you are not available.

(Name of individual)

(Relationship to Patient)

(Patient Name)

(Patient Date of Birth)

(Parent Signature)

(Office Staff Signature)

(Date)

(Date)