

**STANLEY TU, M.D.**

**Patient Personal Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ST/Zip: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Circle Gender: Female Male  
Phone (Home) ( \_\_\_\_ ) \_\_\_\_\_  
Phone (Work) ( \_\_\_\_ ) \_\_\_\_\_  
Phone (Cell) ( \_\_\_\_ ) \_\_\_\_\_  
Occupation / Student: \_\_\_\_\_  
Employer / School: \_\_\_\_\_  
Referred by: \_\_\_\_\_

**Responsible Party Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/ST/Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Social Security Number: \_\_\_\_\_  
Phone (Circle Home/ Work/ Cell) ( \_\_\_\_ ) \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_  
Phone(Home/ Work/ Cell) \_\_\_\_\_  
Phone(Home/ Work/ Cell) \_\_\_\_\_

**Insurance Information**

Insurance carrier: \_\_\_\_\_  
Insurance I.D. #: \_\_\_\_\_  
Type (circle one) HMO PPO POS Medicare Medi-Cal  
Secondary Insurance: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_

**Spouse Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City /ST/ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Phone (Circle Home/Work/Cell): ( \_\_\_\_ ) \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_

**Authorization**

I authorize you to share my protected health information with any of the following persons. This includes allowing them to pick up lab information, prescriptions, other referral information from Foothill Pulmonary and Critical Care Consultants Medical Group, Inc., and to make and receive phone calls regarding my health and or the billing related to the service provided to me by Foothill Pulmonary and Critical Care Consultants Medical Group, Inc.

SPOUSE: \_\_\_\_\_  CAREGIVER: \_\_\_\_\_  
 CHILDREN: \_\_\_\_\_  
 OTHER: \_\_\_\_\_

**ASSIGNMENTS OF BENEFITS**

I hereby assign payment of authorized Medicare and any other medical and/ or surgical benefits, to include major medical benefits to which I am entitled, to be made either for me or on my behalf to Foothill Pulmonary and Critical Care Consultants Medical Group, Inc. for any services furnished to me by the physician/ supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. "I certify that I am eligible for benefits under the pre-paid health benefit plan. In the event I am later found to be ineligible, or as consideration for being treated without proof of eligibility, I agree to pay for any and all services provided by Foothill Pulmonary and Critical Care Consultants Medical Group Inc. at their fees then in effect."

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**HIPPA PRIVACY POLICY**

Our notice of Privacy Practices advises how we may use and disclose protected health information about you. Our current notice is available in our lobby, or upon request. I agree to the uses and disclosure of my information for purposes of treatment, payment and practice operations.

SIGNATURE: \_\_\_\_\_

DATE \_\_\_\_\_