Charles Hsu, M.D.

4610 Sweetwater Blvd. #220
Sugar Land, TX 77479
Phone: 281-242-1127
Fax: 281-242-7478 [CHAS.HSU]

CONFIDENTIAL PATIENT INFORMATION

Patient's Name: _____

Date of Birth: _____ Male: _____ Female: _____

Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Mother's Name: _____ SSN: _____

Date of Birth: _____ Work/Cell Phone: _____

Father's Name: _____ SSN: _____

Date of Birth: _____ Work/Cell Phone: _____

Primary Insurance: _____ Cardholder's Name: _____ SSN: _____

Secondary Insurance: _____ Cardholder's Name: _____ SSN: _____

My child is allergic to: _____

Emergency Contact: _____Phone: _____

CONSENT

I consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicines, conduct of laboratory, x-ray or other studies that may be used by the attending doctor, his nurse or qualified designate. I acknowledge full responsibility of the payment of such services and agree to pay them in full at the time of services unless other arrangement is made with the financial department. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Charles Hsu, MD will assist in billing the insurance company, but I am ultimately responsible for payment to my insurance or third part for the purpose of determining benefits. This authorization will remain unless any change is made in writing.

Parent/Guardian Signature: _____

Date: _____