Takashi Yoshida, MD
2490 Hospital Drive, Suite 103, Mountain View CA 94040 (650) 962-4640

Patient's Name: ______________________ **Birth Date:** ____/____/____ ______
Last Name First Name MM DD YY M/F

Patient's Name: ______________________ **Birth Date:** ____/____/____ ______
Last Name First Name MM DD YY **M/F**

Patient's Name: ______________________ **Birth Date:** ____/____/____ ______
Last Name First Name MM DD YY **M/F**

Address: ______________________ Phone: ______________
Number Street Apt# City Zip Code

Father's Name: ______________________ **Birth Date:** ____/____/____
Last Name First Name MM DD YY
Email Address: ______________________

Employer: ______________________ **Work Phone** ______________

Employer Address: ______________________ **Cell Phone:** ______________

Mother's Name: ______________________ **Birth Date:** ____/____/____
Last Name First Name MM DD YY
Email Address: ______________________

Employer: ______________________ **Work Phone** ______________

Employer Address: ______________________ **Cell Phone:** ______________

Primary Insurance by: **Mother** **Father**

Insurance Plan: ______________ **ID#** ______________ **Group#** ______________

Second Insurance by: **Mother** **Father**

Insurance Plan: ______________ **ID#** ______________ **Group#** ______________

Emergency Contact:

Name: ______________________ **Phone#** ______________

Address: ______________________
Street City Zip Code

I understand my signature requests that payment be made to Takashi Yoshida, MD, Inc., and authorize release of medical information necessary to pay the claim. **I realize I am responsible for keeping my insurance and address current and Up To Date.** In the event any insurance claims are not paid, I will be responsible for the balance on the account. ______
Initials

______________ ______________________ ______________
Relationship to patient Signature of Parent/Guardian Date