Peter N. Schochet, MD
Hauw S. Lie, MD
Board Certified Pediatric Pulmonologists

Patient Profile

Child/Patient Name_____ ◯ Male ◯ Female Date of Birth_____

Patient resides with: ◯ Mother ◯ Father ◯ Other___ Parents Marital Status ◯ Married ◯ Single ◯ Divorced/Separated

Address where Child resides_____ City_____ Zip_____

Race _____ Ethnicity ◯ Hispanic ◯ Not Hispanic Preferred Language _____

Email address _____

Parents/Legal Guardian Information

Mothers Information

Name _____

Date of Birth _____

Address _____

City_____ St____ Zip_____

Home Phone_____ Cell_____

Employer _____

Work Phone_____

Fathers Information

Name _____

Date of Birth _____

Address _____

City_____ St____ Zip_____

Home Phone_____ Cell_____

Employer _____

Work Phone_____

Are other adults approved to bring your child to the visit? ◯ Yes ◯ No Please list their name and inform them to bring ID _____ Emergency contact _____ phone _____

Insurance Information

Insured Name _____

Name of Insurance Company _____ Phone number _____

Patient ID# _____ Group# _____

Do you have any other insurance this includes Medicaid? ◯ Yes ◯ No If so what is the name of the insurance _____

Referring Physician _____ Pediatrician _____

Pharmacy

What is the name of pharmacy and cross street of the local pharmacy you prefer for us to send medications to _____

Do you use a mail order pharmacy? ◯ Yes ◯ No If so what is the name of the pharmacy? _____

Do you give our office permission to retrieve patients Rx history from external sources? This is to include but not limit to pharmacies, other physicians, hospital, etc. ◯ Yes ◯ No

Signature _____ Date _____

Print Name _____

Pediatric Pulmonologists
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