of Asheville

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(828) 277-3000

Peter T. Chu, MD
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Last Name	First Name	Middle Initial	Gender	Birth Date	SSN

Parent Information: (circle one) Married Single Divorced Separated Living Together

Mother

Last Name: ____________________ Home Tel #: ____________________

First, MI: ____________________ Cell #: ____________________

Address 1: ____________________ Work #: ____________ Ext: ________

Address 2: ____________________ Email: ____________________

City: ____________ State: ________ DOB: ____________________

Zip Code: ____________________ SSN: ____________________

Language Preference: ____________________ Employer: ____________________

Preferred Method of Communication: (circle one) Home Cell Work Email

Father

Last Name: ____________________ Home Tel #: ____________________

First, MI: ____________________ Cell #: ____________________

Address 1: ____________________ Work #: ____________ Ext: ________

Address 2: ____________________ Email: ____________________

City: ____________ State: ________ DOB: ____________________

Zip Code: ____________________ SSN: ____________________

Language Preference: ____________________ Employer: ____________________

Preferred Method of Communication: (circle one) Home Cell Work Email

Responsible Party

Name: ____________________ DOB: ____________________ SSN: ____________________

Address: ____

Responsible Party Statement: I hereby authorize ABC Pediatrics to furnish information to insurance carriers concerning my child/children's illness and treatment. I understand that I am financially responsible for all charges whether or not covered by insurance and that unless I am a member of an organization with which ABC Pediatrics is a contracted provider, all charges are due at the time services are rendered.

Relative Authorization:

Name: ____________________ Relationship to Patient: ____________________

Home #: ____________________ Cell #: ____________________

Name: ____________________ Relationship to Patient: ____________________

Home #: ____________________ Cell #: ____________________

Consent to Treat: I hereby authorize and request ABC Pediatrics to provide diagnostics and treatment.

I give the listed persons above permission to bring my child/children to be seen at ABC Pediatrics for diagnosis and treatment.

Parent Signature: ____________________ Date: ____________________