

**Perry Lim, M.D.**

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**Patient Registration Form**

PLEASE PRINT:

**Patient Last Name** \_\_\_\_\_ **First** \_\_\_\_\_ **Middle** \_\_\_\_\_

Gender: M or F (circle) SS#: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Nickname: \_\_\_\_\_ Sibling's Name (s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_ Email address: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Who can we thank: \_\_\_\_\_

Who was your previous physician (if any)? \_\_\_\_\_

**Mother's/Guardian's Name Last** \_\_\_\_\_ **First** \_\_\_\_\_

Relationship to child: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_

Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone # (if different): \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Father's Name Last** \_\_\_\_\_ **First** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SS #** \_\_\_\_\_

Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone # (if different): \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

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**Primary Insurance:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ SS #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ SS #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

*In case of emergency, who should be notified (someone other than the parents)*

Name \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Best way to contact you for appointment reminders (home phone, cell, mail, email): \_\_\_\_\_

Would you like to receive our email newsletter? (news, health tips, medical advice, etc): Yes No (circle)

If yes, email address: \_\_\_\_\_