**Robert Langston MD, Dr. Katherine Johnston MD, Dr. Lucy Hume MD**
3838 California Street
Suite 815
San Francisco, CA 94118

**REFERRED BY WHOM: _____ Obstetrician: _____**

Patient's Name_____
Last First Middle
Date of Birth_____ Sex_____ Age_____

Address_____

City_____Zip_____

Phone (Please circle HM or CELL) _____

I have chosen Robert Langston, MD, as the provider of medical care for my child. I understand that it is my responsibility to enroll my child to an insurance plan. I authorize his staff to bill the above insurance carriers for my child's services. I understand that I will be billed for any denied services or for services not covered within 30 days by my insurance carrier. I also understand that a fee of $35.00 will be charged for a copy for any medical records requested.
By initialing, you have read and understand above ____

Parent's
Signature_____Date_____