

MIAMI ASSOCIATES IN PEDIATRIC SURGERY, P.A.
PATIENT INFORMATION

Today's Date _____

Patient's Name _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____ Home Phone # _____

City _____ State _____ Zip _____ Cell Phone # _____

Father's Name _____ D.O.B. _____ S.S.# _____

Father's Employer: _____ Occupation: _____

Business Phone # _____ Business Address: _____

Mother's Name _____ D.O.B. _____ S.S.# _____

Mother's Employer: _____ Occupation: _____

Business Phone # _____ Business Address: _____

Responsible Party's Name: _____

Responsible Party's Driver's License #/State: _____

IN CASE OF EMERGENCY: Name of the nearest friend or relative who does not reside with you.

Name: _____ **Telephone #** _____

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE: _____ HMO [] PPO [] GROUP [] PRIV []

Insurance Company Address: _____

Insured's Name _____ I.D. # _____ Group # or Name _____

SECONDARY INSURANCE: _____ HMO [] PPO [] GROUP [] PRIV []

Insurance Company Address: _____

Insured's Name _____ I.D. # _____ Group # or Name _____

REFERRING M.D. INFORMATION

PRIMARY CARE DOCTOR : _____ TEL. NO. _____

REFERRING DOCTOR: _____ REF. DR'S. PHONE _____

REFERRING DOCTOR'S ADDRESS: _____

Authorization to Release Information: I hereby authorize **Miami Associates in Pediatric Surgery, P.A.** to release any information acquired in the course of my examination and treatment of the above named patient.

Insurance Authorization and Assignment: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to: **Miami Associates in Pediatric Surgery, P.A.** This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all the charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I have received from **Miami Associates in Pediatric Surgery, P.A.** the "Notice of Privacy Practices".

Signed _____ Date _____

Relationship to Patient _____