REYES PEDIATRICS

PATIENT REGISTRATION FORM

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____

Street Address: _____ Home Tel: (_____) _____

City, State & Zip: _____ Social Security # _____

Other Tel (cell, etc.) _____ E-MAIL_____Sex (please circle): Male / Female

Primary Language (please circle): English / Spanish / Other: _____**Race**_____**Ethnicity**_____

IF PATIENT IS A MINOR: FATHERS NAME_____MOTHERS NAME_____
BIRTHDAY_____ BIRTHDAY _____

EMERGENCY CONTACT

Name: _____ Tel: (_____) _____

Relationship to patient: _____

PERSON RESPONSIBLE FOR PAYMENT: _____

ADDRESS OF RESPONSIBLE PERSON: _____

INSURANCE INFORMATION

Primary: _____ Med. Group: _____

Insurance ID #: _____ Group #: _____

Claims Address: _____

Father's Employer: _____Occupation:_____

Address: _____ Bus. Phone: _____

Mother's Employer: _____ Occupation: _____

Address: _____Bus Phone: _____

List the names of the persons that you authorize us to give information:

_____

_____

ASSIGNMENT OF BENEFITS

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH THE ABOVE NAMED CARRIER AND ASSIGN DIRECTLY TO MY OFFICE ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I HEREBY AUTHORIZE Elizabeth R Reyes, M.D. TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

SIGNATURE: _____ DATE: _____