Patient Registration (please print)

Date:_____ Cell Phone Parent #1:_____

Cell Phone Parent #2: _____

_____ _____ M ___ F ___
Patient's Name (Last, First, MI) Birth Date (MM/DD/YYYY

_____ _____ _____
Race Ethnicity Language(s)

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ _____
Name of Parent/Guardian #1 Relationship to Patient Email Address

_____ _____ _____ _____
Street Address (if different) City State Zip Code

_____ _____ _____
Birth Date (MM/DD/YYYY) Occupation Employer

_____ _____ _____
Name of Parent/Guardian #2 Relationship to Patient Email Address

_____ _____ _____ _____
Street Address (if different) City State Zip Code

_____ _____ _____
Birth Date (MM/DD/YYYY) Occupation Employer

Who to Contact If We Cannot Reach Parent/Guardian in An Emergency?

_____ _____ _____
Name Relationship to Patient Cell Phone

INSURANCE INFORMATION

_____ _____
Name of Primary Insurance Company Name of Policy Holder

_____ _____
Insurance Identification Number Group Number

The guarantor is responsible for all fees. Fees are due at time of service.
Please read and sign the following Authorization and Assignment.

Insurance Authorization & Assignment

I hereby authorize Ofelia B. Ayuste, M.D.S.C. to furnish information to my insurance company carrier concerning my child or children's illness or treatment. I also hereby assign the Doctor all outstanding payments for medical services rendered to my dependent(s). I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

Insured/Parent's Signature: _____

A photocopy of this Authorization shall be considered as valid as the original