

TEST, TINA (id #1, dob: 01/01/2006)

Registration

TEST, TINA 01/01/06 #1



* 742870w11453 Admin

Family Name		A		Address	
Phone				City:	
Cell:				State:	
Home:				Zip:	
Preferred Pharmacy:				Pharmacy Location:	
Required my government mandate [although you may refuse]		Language:		Ethnicity:	
Patient Name					
Name:		DOB		M F	
Name:		DOB		M F	
Name:		DOB		M F	
Parents / Guardians					
Mother's Name:			Father's Name		
Mother's Email:			Father's Email		
Mother's Cell:			Father's Cell:		
<i>How would you preferred to be reached?</i>					
Cell	SMS	Email	Potal	All	
Insurance					
Policy Holder Name:			Policy Holder DOB:		
Effective Insurance Date:			Policy Holder's Employer:		
Acknowledgement and Authorization					
I have read and understand the HIPAA/Privacy Policy for Salud Pediatrics <input type="checkbox"/>					
I hereby assign my insurance benefits to be paid directly to the healthcare provider					
I authorize Salud Pediatrics to release medical information required to process my child's claim					
I have read and understand the Parent Agreement for Salud Pediatrics					
I authorize Salud Pediatrics to contact me by mobile phone					
Name:		Signature:			
Relationship to the Patient:		Date:			