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

TEST, TINA 01/01/06 #1

* 742870w11453 Admin

Family Name	**Address**
Phone	City:
Cell:	State:
Home:	Zip:
Preferred Pharmacy:	Pharmacy Location:
Required my goverment 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:
How would you preferred to be reached?				
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 ☐	
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: