PEDIATRIX CARDIOLOGY OF ORLANDO

Date______________________

PATIENT NAME____DOB_________________ SEX: M OR F

ETHNICITY__________RACE___________

HOW WELL DO YOU SPEAK ENGLISH? A) VERY WELL B) WELL C) NOT WELL D) NOT AT ALL

STREET ADDRESS____CITY_______________________STATE______ZIP________

CELL PHONE (IF OVER 18) _____________________________ SOCIAL SECURITY # (IF OVER 18) ___________________________

EMAIL ADDRESS (IF OVER 18) ____

PARENT NAME_________________________________RELATIONSHIP___________DOB_________________SSN_____________________

STREET ADDRESS____CITY______________________STATE______ZIP_________

HOME PHONE________________________________CELL PHONE_____________________________

EMAIL ADDRESS____

EMPLOYER____PHONE________________________

PARENT NAME_________________________________RELATIONSHIP___________DOB_________________SSN______________________

STREET ADDRESS____CITY_______________________STATE______ZIP_________

HOME PHONE________________________________CELL PHONE_____________________________

EMAIL ADDRESS____

EMPLOYER____PHONE_______________________________

PEDIATRICIAN/PRIMARY CARE____PHONE_______________________________________

CONSENT FOR TREATMENT…AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

PARTICIPATING INSURANCE - I hereby give consent to Pediatrix Cardiology of Orlando to provide whatever treatment they may deem necessary to the patient above. I hereby request payment of authorized benefits and/or insurance benefits to be paid directly to Pediatrix Cardiology of Orlando for any services furnished to the patient by Pediatrix Cardiology of Orlando. I authorize Pediatrix Cardiology of Orlando and staff to release to my insurance carrier and its agents any information concerning healthcare, advice, treatment provided to the patient needed to determine these benefits or the benefits payable for related services. I understand I am responsible for charges not covered by the insurance policy, and should it become necessary to collect the charges through an attorney or other collection process, I shall be responsible for all costs.

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Signature of patient / responsible party if minor **Date**