

Pediatric Medical Group of Florida, Mas, MD.,Pereira MD.,Pumarino MD

Do you speak English: _____ Very Well _____ Well _____ Fair _____ Poor Language: _____

Name/Nombre _____ DOB/fecha de nacimiento: _____

SS #/ Seguro social: _____ Telephone: _____ Cel# _____

Address/Direccion: _____ City/state/Ciudad/Estado/ _____ Zipcode _____

Spouse's Name: _____ Date of Brith: _____ SS# _____

Address: _____ Apt: _____

City/State: _____ Zip/Zona postal: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relation: _____

Phone: _____ Cell Phone: _____

Obgy Referring Physician, _____ Phone# _____

EMPLOYMENT INFORMATION/ INFORMACION DE EMPLEO

Employed by/ empleador _____ telephone _____

Address/ Direccion _____ State/ Estado _____ zip/ codigo _____

INSURANCE INFORMACION/ INFORMACION DE SEGURO

Primary ins/ seguro primario _____ Policy _____ Grp _____

Name of Insured: _____ DOB: _____ SS# _____

FINANCIAL RESPONSIBILITY/ HMO REFERRAL # / AUTHORIZATION/ RESPONSABILIDAD FINANCIERA/ REFERIDO Y AUTHORIZACIONES.

I, _____ a member of _____
Yo, _____ miembro de _____

Hereby acknowledge and fully understand that I am financially responsible for payment of the services rendered on the above date of service if no referral or authorization is provided.
Yo entiendo perfectamente que soy responsable de los gastos y cargos de los servicios proveidos en la fecha de arriba si un referido u autorizacion no es entregado.

Assignment and Release

I hereby authorize that payment be made directly to the above mention doctors or benefits due to me from my insurance company otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize doctors to release information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Yo autorizo que los pagos sean hechos directamente a los doctores mencionados arriba o beneficios debidos a mi compania de seguros sean pagos a mi. Yo entiendo que soy responsable por todos los cargos sean pagados o no por mi compania de seguro. Yo autorizo a los doctores que den toda la informacion necesaria para asegurar el pago de los beneficios. Yo athorizo el uso de mi firma provista aqui en todo lo que se refirer a mi seguro.

SIGNATURE/ FIRMA _____ Date/Fecha _____

Declined Interpreter YES NO