REGISTRATION / *REGISTRO*

Date / *Fecha*: ____/_____/____ MRN: ________________

Patient's Name / *Nombre del Paciente*: ____

Sex / *Sexo*: ______ Date of Birth / *Fecha de Nacimiento*: ___/____/___ Age / *Edad*: ____

Patient's Address / *Direccion*: ____ City / *Ciudad*: ____________________

State / *Estado*: ________ Zip Code / *Codigo Postal*: ___________

PARENT / GUARANTOR / *PADRE O GARANTE*

Mother's Name / *Nombre de la Madre*: ________________________________Date of Birth / *Fecha de Nacimiento*: ___/____/___

Employer / *Empleador*: __________________________ Address / *Direccion*: ___________________________________

Phone Numbers / *Numeros telefonicos*: (____) ______-_________

Father's Name / *Nombre del Padre*: ___________________________________ Date of Birth / *Fecha de Nacimiento*: ___/____/___

Employer / *Empleador*: __________________________ Address / *Direccion*: ___________________________________

Phone Numbers / *Numeros telefonicos*: (____) ______-_________

Guarantor's Name / *Nombre del Garante*: ________________________________ Date of Birth / *Fecha de Nacimiento*: ___/____/___

Employer / *Empleador*: __________________________ Address / *Direccion*: ___________________________________

Phone Numbers / *Numeros telefonicos*: (____) ______-_________

RESPONSIBLE PARTY / GUARDIAN / *PARTE RESPONSIBLE O GUARDIAN*

Name / *Nombre*: ________________________________ Relationship / *Relacion*: ________________

Date of Birth / *Fecha de Nacimiento*: ___/____/___

Phone Numbers / *Numeros telefonicos*: Home / *Casa* (____) ______-________ Cell / *Celular* (____) ______-________

<u>EMERGENCY CONTACT / *CONTACTO DE EMERGENCIA*</u>

Name / *Nombre:* ___________________________ Relationship / *Relacion:* ________________ Phone Numbers / *Numeros telefonicos*: (____) ______-_________

Name / *Nombre:* ___________________________ Relationship / *Relacion:* ________________ Phone Numbers / *Numeros telefonicos*: (____) ______-_________

<u>INSURANCE INFORMATION / *INFORMACION DEL SEGURO*</u>

Primary Insurance / *Seguro Primario*

Primary Insured / *Asegurado Primario*: _______________________ Date of Birth / *Fecha de Nacimiento*: ___/____/___ Relationship / *Relacion:* ________________

Name of Insurance / *Nombre de Seguro:* ____

Member ID# / *Numero de Miembro*: ___________________________ Group # / *Numero de Grupo*: ____________________ Effective Date: ____/_____/_____

RELEASE OF INFORMATION AND ASSIGNMENT

I hereby authorize Westchester Park Pediatrics to release information concerning treatment or services rendered to Medicare / other insurance carriers responsible for my or my dependent's care. I request that payment of authorized Medicare / other insurance company benefits be made either to me or on my behalf to Westchester Park Pediatrics for any services rendered. I have been advised that if my insurance requires a co-pay, it is due at the time of the visit. Otherwise, a $20 surcharge will be added to my bill.

Signature of Parent / Guardian / *Firma del Padre / Guardian:* **Date / *Fecha:***

X____ _____________________________________