PATIENT INFORMATION

Name: _____ **DOB:** _____ **Age:** _____ **Sex:** _____

Address: _____ **Apt:** _____ **City:** _____ **Zip Code:** _____

Phone: _____ **Allergies:** _____

Referred By: _____ **Previous Doctor:** _____

PARENTS INFORMATION (IF THE PATIENT IS A MINOR)

Mother: _____ **DOB:** _____

Cell Phone: _____ **Work Phone:** _____

Home Phone: _____

Father: _____ **DOB:** _____

Cell Phone: _____ **Work Phone:** _____

Other Phone: _____

Emergency Contact/Relationship: _____

Phone: _____

PAYMENT RESPONSIBILITY

Parent Name: _____

Insurance Name: _____**Policy Name/Number:** _____

Medicare: _____ **Medicaid:** _____**Cash:** _____ **Other Insurance:** _____

AUTORIZACION: I authorize my insurance benefits to be payable to Cesar Parra MD Medical Clinic. I also certify that I will be responsible for the rest of the expenses that are not covered. I authorize this clinic and his doctors to provide all the information necessary to the insurance companies.

Date: _____ **Signature:** _____