CARING HANDS PEDIATRICS PC

183-11 Hillside Avenue
Suite AA
Jamaica, NY 11432
Tel: 718-570-4650
Fax:718-570-4648

PATIENT REGISTRATION

Name _____ Date of Birth _____/ _____/_____

Sex _____ F _____ M Referred By _____

Address _____ Apartment # _____

City _____ State _____ Zip _____ Phone ( ) _____

Email _____

Father's Name _____ Father's SS # _____

Work Phone or Cell Phone ( ) _____

Mother's Name _____ Mother's SS # _____

Work Phone or Cell Phone ( ) _____

INSURANCE AND BILLING INFORMATION

Person Responsible _____ Father _____ Mother _____ Other_____

Relationship _____

Billing Address _____

PAYMENT REQUIRED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

1 Insurance Company _____

Address _____ Phone # ( ) _____

Effective Date _____

Policy # _____ Group # _____

PATIENT NAME _____ DATE OF BIRTH _____ / _____ / _____

2 Insurance Company _____

Address _____ Phone # ( ) _____

Effective Date _____

Policy # _____ Group # _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Dr. Ma Jesusa Christina Calagos for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balances not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Ma Jesusa Christina Calagos to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. A photocopy of these assignments shall be valid as the original.

Patient (please print) _____ Date _____ / _____ / _____

Parent/Guardian (please print) _____

Signature _____

OFFICE POLICY ACKNOWLEDGMENT

I have received a copy of the office's policy and have been provided the opportunity to review it.

Patient (please print) _____ Date _____ / _____/_____

Parent/Guardian (please print) _____

Signature _____