Eduardo Diaz, MD PA
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PATIENT REGISTRATION
REGISTRO DEL PACIENTE

Acct #: _____

Patient Name: _____ DOB: _____ Age: _____
(Nombre del paciente) (Fecha de nacimiento) (Edad)

Patient's SSN: _____ Sex: _____ Ethnicity: _____
(Seguro Social) (Sexo) (Raza)

Address: _____
(Direccion)

City:_____ State:_____ Zip Code_____ E-Mail:_____
(Ciudad) (Estado) (Codigo Postal) (Correo electronico)

Home Telephone:_____ Cell:_____
(Telefono de la casa) (Celular)

Family Preferred method of communication (Check one): Ph: _____ E-mail: ____ Mail: _____
(Metodo de comunicacion Preferido) (Marque uno)

Preferred Language: _____ Pharmacy Ph: _____
(Idioma de preferencia) (# de farmacia)

Mother's Name: _____ SSN: _____
(Nombre de la madre) (# de seguro social)

Employer's Name: _____ Telephone: _____
(Nombre del empleador) (Telefono)

Father's Name: _____ SSN: _____
(Nombre del padre) (# de seguro social)

Employer's Name: _____ Telephone:_____
(Nombre del empleador) (Telefono)

Emergency Contact:_____Telephone:_____ Rel. to Pt.:_____
(Contacto de Emergencia) (Telefono) (Relacion con el paciente)

Primary Insurance: _____ Insurance ID: _____
(Seguro Primario) (Numero de Membresia)

Policy Holder: _____ DOB: _____ Rel. to Pt._____
(Nombre del Asegurado Principal) (Fecha de Nac.) (Relacion con el paciente)

Secondary Insurance:_____ Insurance ID:_____
(Seguro Secundario) (Numero de Membresia)

Policy Holder: _____DOB: _____ Rel. to Pt._____
(Nombre del Asegurado) (Fecha de Nacimiento) (Relacion con el paciente)

All office fees are to be paid at the time services are rendered. Your medical Insurance is a contract between you and your insurance company, whose payments for our services vary according to the terms of your policy. Final payment of all charges is the patient's responsibility. I hereby authorize payment directly to **Eduardo Diaz, MD PA (AKA Dr. Diaz Pediatrics)** of all benefits applicable, if any, and otherwise payable to me for services rendered. I understand I am responsible to **Eduardo Diaz, MD PA** for charges not covered by this assignment. I authorize release of information to all my insurance companies. I authorize use of this form on all my insurance submissions. I permit a copy of this authorization to be used in place of the original. The undersigned consents to treatment of the patient under the doctor's medical advise.

_____ _____

Patient/ Parents Signature
Firma del Paciente/Padre/Madre

Date/ Fecha