Date_____
Fecha

Patient Registration
Registracion del Paciente

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information - *Informacion del Paciente*

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Sex _____ Date of Birth _____
Sexo *Fecha de Nacimiento*

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Esado Civil *Casada* *Soltera* *Divorciada* *Viuda*

Race/Ethinicity _____
Raza/Etnia

(Check One) ☐ Employed ☐ Retired ☐ Full-Time Student
Marque Uno *Empleada* *Retirada* *Estudiante Tiempo Completo*

☐ *Other* _____
Otro

Employer _____
Empleador

Work Phone (_____) _____
Telefono de Trabajo

Home Address _____
Direccion del Hogar

City _____ State_____ Zip _____
Cuidad *Estado* *Codigo Postal*

Email Address _____

Home Phone (____)_____ *Cell Phone* (____)_____
Telefono del Hogar *Telefono Cellular*

I was referred to: _____ *by I por*
Fui recommendado por

☐ *Friend* _____ ☐ *Relative* _____
Amigo *Familiar*

☐ *Physician* _____ ☐ *Insurance* _____
Medico *Seguro*

☐ Reputation of the LLC's Physicians _____
Reputacion de los Medicos del LLC

☐ Reputation of the LLC's Physicians _____
Reputacion de los Medicos del LLC

Insurance Information - *Informacion del Seguro*

Please provide your insurance card to the recptionist - *Por favor entregue su tarjeta de seguro da la receptionista*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compania de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado

Policy # _____ Group # _____ Phone ( ) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Secondary Insurance Information - *Informacion del Seguro*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compania de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado

Policy # _____ Group # _____ Phone ( ) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Emergency Contact - *En Emergencias, Contactar a:*

Social Security # _____ *Sex* _____
Numero de Seguro Social *Sexo*

First Name _____ Middle _____ Home Phone (_____) _____
Primer nombre *Segundo Nombre* *Telefono del Hogar*

Last Name _____ Work Phone (_____) _____
Apellido *Telefono del Trabajo*

Pharmacy - *Farmacia*

Pharmacy _____ Pharmacy Address _____
Farmacia *Direccion de la farmacia*

Pharmacy Phone _____
Numero de telefono de la farmacia

Spouse / Guarantor / Responsible Party - Exposo / Persona Responsabe

Social Security # _____ Sex _____ Date of Birth _____/_____/_____
Numero de Seguro Social *Sexo* *Fecha de nacimiento*

Relationship _____ Daytime Phone (_____) _____
Relacion *Telefono durante el dia*

First Name _____ Middle_____ Employer _____
Primer Nombre *Segundo Nombre* *Empleo*

Last Name _____ Address _____
Apellido *Direccion*

Address _____ City _____ State_____ Zip_____
Direccion *Ciudad* *Estado* *Codigo Postal*

City _____ *State* _____ *Zip* _____
Cuidad *Estado* *Codigo Postal*

Signature Required Please See Reversed Side
Firma Reqerida. Por Favor mira al Dorso

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection. I understand that I will liable for any charges incurred, including attorney's fees and court costs.

Todos los honararies por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminus de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsible de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgment up to the minimum amounts pursuant to S.458.320 (5) (g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5)(g). Florida impone penas contra los medicos de los no asegurado que no pueden satisfacer los juicios adversos que se presetantan de demandas de la neglicgencia medica. Este aviso esta conforme a la ley florida.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que anupara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compana de seguro para procesar mi reclamacion. Yo entiendo que soy responsible por todos los caros no cubiertos baja mi seguro medico.

_____ _____

PATIENTS/ GUARANTOR'S SIGNATURE DATE