Dr. Josephine Ruiz Healy M.D.

DATE: _____

HOME PHONE: _____

PATIENT INFORMATION (Please Print)

Name of Minor/Child _____

Last Name **First Name** **Middle Initial**

Sex M◯ F◯ Age _____ Birthdate _____ Nickname _____ Hobbies _____

Home Address _____

Street City State Zip

Mailing Address _____

Street City State Zip

Person financially responsible: _____ Cell Phone: _____ Work Phone: _____

E-MAIL: _____

Whom may we thank for referring you? _____

Best number to contact you? _____

RESPONSIBLE PARTY AND/OR INSURANCE INFORMATION

Father's/Guardian's Name _____

Address (If different from patient's) _____

_____

Cell Phone _____ Work Phone _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have ins. coverage for the minor? Y◯ N◯

Plan Name _____

Policy ID # _____

Group # _____

Address _____

_____

Phone # _____

Mother's/Guardian's Name _____

Address (If different from patient's) _____

_____

Cell Phone _____ Work Phone _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have ins. coverage for the minor? Y◯ N◯

Plan Name _____

Policy ID # _____

Group # _____

Address _____

_____

Phone # _____

EMERGENCY CONTACT

In an event of an emergency, whom should we contact? **(Other than parents)**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it my responsibility to inform this office of any changes in my minor/ child's medical status.

I certify that my minor/child is covered by insurance with _____ and assign directly

Name of Insurance Company/ OR if Self Pay

to ***Dr. Ruiz-Healy*** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**, I hereby authorize the the doctor release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. **I also acknowledge that there will be a $25.00 fee for appointments not cancelled within a 24 hr notice or NO SHOW, and after the 3rd I will be dismissed from the practice.**

_____ _____

Signature of Parent/Guardian **Date**