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
Name of Insurance Company/ OR if Self Pay

directly 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**