

PATIENT INFORMATION

Today's Date _____

Name of Patient: _____

Male _____

Female _____

Birthdate: _____

Address: _____

City _____ State _____ Zip _____

Home Phone: (_____) _____ Cell phone: (_____) _____

Pediatrician: _____ Phone: (_____) _____

Referring Physician: _____ Phone: (_____) _____

+++++
Mother's Name: _____ Birthdate: _____ SSN#: _____

+++++
Father's Name: _____ Birthdate: _____ SSN#: _____

+++++
Primary Insured's Name: _____

Address:(if other than above) _____

City: _____ State _____ Zip _____ Phone(_____) _____

Insurance Company: _____

Group#: _____ ID# _____ Birthdate: _____

Employer' Name: _____

Address: _____

City: _____ State _____ Zip _____ Phone(_____) _____

+++++
Secondary Insured's Name: _____

Address:(if other than above) _____

City: _____ State _____ Zip _____ Phone(_____) _____

Insurance Company: _____

Group#: _____ ID# _____ Birthdate: _____

Employer' Name: _____

Address: _____

City: _____ State _____ Zip _____ Phone(_____) _____

Does patient have any allergies to medications:

____ Yes

Is so, please list:

____ No

I authorize the release of any medical or other information necessary to process this claim. I authorize the release of medical records to any physicians regarding the treatment of this patient and to anyone listed below. I also authorize payment of medical benefits to:

ALPERT, ZALES AND CASTRO PEDIATRIC CARDIOLOGY, P. A.
MITCHEL B. ALPERT, M. D.
VINCENT R. ZALES, M. D.
ELSA I. CASTRO, M. D.

Signature

Print Name