Pediatrix Medical Group of Florida, Mas, MD.,Pereira MD.,Pumarino MD

Do you speak English: _____Very Well _____Well _____Fair _____Poor Language:

Name/Nombre_____DOB/fecha de nacimiento:_____

SS #/ Seguro social:_____Telephone:_____Cel#_____

Address/Direccion:_____City/state/Ciudad/Estado/_____Zipcode_____

Spouse's Name:_____Date of Brith:_____SS#_____

Address:_____Apt:_____

City/State:_____Zip/Zona postal:_____

Home Phone:_____Cell Phone:_____

Emergency Contact:_____Relation:_____

Phone:_____Cell Phone:_____

Obgy Referring Physician,_____ Phone#_____

EMPLOYMENT INFORMATION/ INFORMACION DE EMPLEO

Employed by/ empleador_____ telephone_____

Address/ Direccion_____State/ Estado_____zip/ codigo_____

INSURANCE INFORMACION/ INFORMACION DE SEGURO

Primary ins/ seguro primario_____Policy_____Grp_____

Name of Insured:_____DOB:_____SS#_____

FINANCIAL RESPONSIBILITY/ HMO REFERRAL # / AUTHORIZATION/ RESPONSABILIDAD FINANCIERA/ REFERIDO Y AUTHORIZACIONES.

I, _____a member of_____
Yo, miembro de

Hereby acknowledge and fully understand that I am financially responsible for payment of the services rendered on the above date of service if no referral or authorization is provided.
Yo entiendo perfectamente que soy responsible de los gastos y cargos de los servicios proveidos en la fecha de arriba si un referido u autorizacion no es entregado.

Assignment and Release

I hereby authorize that payment be made directly to the above mention doctors or benefits due to me from my insurance company otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize doctors to release information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Yo authorizo que los pagos sean hechos directamente a los doctores mencionados arriba o beneficios debidos a mi compania de seguros sean pagos a mi. Yo entiendo que soy responsible por todos los cargos sean pagados o no por mi compania de seguro. Yo autorizo a los doctores que den toda la informacion necesaria para asegurar el pago de los beneficios. Yo athorizo el uso de mi firma provista aqui en todo lo que se refirer a mi seguro.

SIGNATURE/ FIRMA_____Date/Fecha_____

Declined Interpreter YES NO