



FLORIDA PEDIATRIC PULMONOLOGY

15740 New Hampshire Court, Suite B
Fort Myers, FL 33908

PATIENT REGISTRATION FORM

PATIENT'S LEGAL NAME:
DATE OF BIRTH: AGE: M/F SSN:
MAILING ADDRESS:
CITY, STATE, ZIP:
REFERRING DOCTOR:

PARENT OR GUARDIAN:
FATHER'S NAME: SSN:
EMPLOYER:
ADDRESS: PHONE# ()
MOTHER'S NAME: SSN:
EMPLOYER:
ADDRESS: PHONE# ()

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE:
ADDRESS:
CITY, STATE, ZIP:
PHONE#: () SUBSCRIBER:
SUBSCRIBER SSN: DATE OF BIRTH:

NAME OF SECONDARY INSURANCE:
ADDRESS:
CITY, STATE, ZIP:
PHONE#: () SUBSCRIBER:
SUBSCRIBER SSN: DATE OF BIRTH:

EMERGENCY CONTACT INFORMATION

NAME: RELATION TO PATIENT:
HOME PHONE: () WORK PHONE: ()
MOBILE PHONE: ()

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ ASSIGNMENT OF BENEFITS

I AUTHORIZE FLORIDA PEDIATRIC PULMONOLOGY TO FURNISH MEDICAL INFORMATION TO MY INSURANCE CARRIER RELATING TO THE MEDICAL CARE RENDERED BY.

I HEREBY AUTHORIZE FLORIDA PEDIATRIC PULMONOLOGY TO GIVE MY MINOR CHILD THE NECESSARY TREATMENT HE or SHE MAY NEED.

I AUTHORIZE PAYMENTS OF MEDICAL BENEFITS TO FLORIDA PEDIATRIC PULMONOLOGY FOR ANY MEDICAL CARE RENDERED TO MYSELF OR TO MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

SIGNATURE

DATE