CARLOS I. FLORES, MD

PATIENT REGISTRATION: ALL ITEMS MUST BE COMPLETED

Child's Name_____ Birth Date:_____ Sex: M F

Child's Address_____ S.S. Number:_____

_____ Home Phone:_____

School Child Attends_____ Work Phone:_____

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Emergency Contact_____ Phone:_____

That persons relationship to the child_____

2nd Emergency Contact_____ Phone:_____

That persons relationship to the child_____

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Child's Father's Name_____ Child's Mother's Name_____

Father's S.S. Number:_____ Mother's S.S. Number:_____

Father's Birthdate:_____ Mother's Birthdate:_____

Father's Employer_____ Mother's Employer_____

Name of person receiving a statement or bill_____

Address_____ Phone Number:_____

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INSURANCE INFORMATION

1. Insurance Company_____

   Insured Person or Subscriber_____ Relationship to Patient_____

   Identification Number_____ Group Number_____

2. Insurance Company_____

   Insured Person or Subscriber_____ Relationship to Patient_____

   Identification Number_____ Group Number_____

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I authorize release of medical information necessary for processing of insurance claims. I hereby assign payment of medical benefits to Carlos I. Flores, MD, PC. I agree that I am responsible for payment of deductible, co-payments, and any amounts not covered by my health plan, and insurance coverage does not relieve me of my financial responsiblity for services provided. I also agree the person requesting treatment for the child is responsible for payment, regardless of a divorce agreement and/or disputes between parents.

SIGNED_____ DATE_____