Welcome to Children's Medical Center. We look forward to providing the best pediatric care for your child.

Attached you will find forms to be completed prior to your scheduled appointment. Please bring the completed forms, along with your child's insurance card and immunization record, to the first visit.

You can also fax the forms to the office of your appointment.

If your appointment is scheduled at:	Please fax forms to:
4651 Sheridan St, Hollywood, FL	(954) 967-8962
12251 Taft Street, Pembroke Pines, FL	(954) 435-7185
20170 Pines Blvd, Pembroke Pines, FL	(954) 378-1530

We will verify your insurance information and set up your chart prior to the appointment, to make your visit more accommodating.

Should you have any questions, please call our office directly.

Thank you and see you soon!

Children's Medical Center, P.A.

New Patient Name(s) **LEGAL NAME ONLY**	Social Security#	Sex	Date of Birth	Birth Weight

Are there any siblings that are established patients at Children's Medical Center? Y / N (if Yes, what are their names?)_____

Father/Guardian_____ Mother/Guardian_____

SS#_____ DOB_____ SS#_____DOB_____

Cell Phone #_____ Cell Phone #_____

E-mail address_____ E-mail address_____

Address_____
City State Zip Code

Marital Status_____ Major Languages spoken at home_____

Home Phone #_____ Preferred Pharmacy Name_____ Pharmacy Phone #_____

Preferred Physician_____

Financial Responsibility (if different than above)_____ Relationship to patient_____

Address_____
City State Zip Code

Father's Employer_____ Mother's Employer_____

Address_____ Address_____

Work #_____ Work #_____

Emergency Contact Name (other than Parents)_____

Phone _____ Relationship_____

Services rendered are charged to the patient and not to the Insurance Company. Therefore we cannot accept an insurance form as payment on your account. Payment is due upon the receipt of services. We will be happy to assit you in filing your insurance forms. If collection becomes necessary, the Undersigned shall pay all costs, including attorney's fees. Please note our office, can use all contact information you give us to contact you as needed.

Signature_____ Date_____

INSURANCE INFORMATION

_____ Regular Insurance _____
Name of Insurance

_____ PPO Insurance_____
Name of Insurance

_____ HMO Insurance_____
Name of Insurance

Primary Insured Name_____ Date of Birth_____

Policy #_____ Group #_____

Effective Date_____ SS# (of Policyholder) _____

Co-Payment $_____ Deductible (if any) $_____ Co-Insurance (if any) _____%

Secondary Insurance (if applicable)_____

Insured Name_____ Date of Birth_____

Policy #_____ Group #_____

Effective Date_____ SS # (Policyholder)_____

A copy of your insurance card(s) is necessary to be kept on file. It is a patient's responsibility to notify this office in the event of any information changes. The patient is responsible for any co-payment, deductible, co-insurance and /or any non-covered services.

Signature_____ Date_____

Primary Insured's Name: _____

Policy #: _____

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize any Doctor or Hospital who has attended me to give_____ Insurance Company, or its representatives, any and all information, including history records, which may be deemed necessary by the Company.

Signature_____
Parent or Legal Guardian

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize payment to Children's Medical Center, P.A. such payment, as would be otherwise payable to me. I understand that I am financially responsible to the Doctor for charges not covered by my assignment.

Signature_____
Parent or Legal Guardian

Name of Patients:
_____
_____
_____
_____

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ D.O.B. _____
_____ D.O.B. _____
_____ D.O.B. _____
_____ D.O.B. _____

PREVIOUS DOCTOR INFORMATION:

PHYSICIAN/PRACTICE NAME_____

ADDRESS:_____
_____
CITY STATE ZIP CODE

_____ _____
PHONE # FAX #

I HEREBY REQUEST THAT THE ABOVE PATIENT'S MEDICAL RECORDS BE RELEASED TO: (CIRCLE ONE)

CHILDREN'S MEDICAL CENTER, P.A.

4651 SHERIDAN STREET, #270	**12251 TAFT STREET, #201**	**20170 PINES BLVD, #203**
HOLLYWOOD, FL 33021	**PEMBROKE PINES, FL 33027**	**PEMBROKE PINES, FL 33029**
PHONE (954) 989-6000	**PHONE (954) 435-7000**	**PHONE (954) 378-1500**
FAX (954) 967-8962	**FAX (954) 435-7185**	**FAX (954) 378-1530**

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

PRINT NAME: _____

RELATIONSHIP TO PATIENT:_____