VIP PEDIATRICS LLC
OLGA ECHEVERRIA,MD
BOARD CERTIFIED PEDIATRICIAN
2300 N COMMERCE PARKWAY SUITE 113, WESTON FL 33327
PHONE (954)251-0011 FAX (954) 251-0011

PATIENT REGISTRATION

PATIENT
LAST NAME____________________________NAME____
BIRTH DATE : ________________ BIRTH PLACE (HOSPITAL): _____________________________________
AGE: ____________ GENDER: FEMALE ___ MALE ____PRIMARY LANGUAGE____________________
RACE: WHITE __ ASIAN__ AFRICAN AMERICAN __ HAWAIIAN__ PACIFIC ISLANDER__ DECLINE__
ETHNICITY: HISPANO/LATINO ___ NO HISPANIC/LATINO ___ DECLINE __
ADDRESS ____
PHONE________________ CELLPHONE_____________________
HOMEPHONE______________________
EMAIL____

PARENTS
MOTHER'S NAME: ____________________________________ D.O.B: _________ AGE_________________
PHONE: _________________________ EMAIL: ____
OCCUPATION: ______________________________ WORK PHONE ________________________________
FATHER'S NAME: __________________________________ D.O.B: _________ AGE_________________
PHONE: ________________________ EMAIL: ____
OCCUPATION: ______________________________ WORK PHONE ________________________________
PARENT'S MARITAL STATUS: SINGLE ____ MARRIED _____ DIVORCED ______ WIDOWED __
__

SIBBLINGS
NAME: ____AGE:_________ D.O.B: _______________
NAME: ____AGE:_________ D.O.B: _______________
NAME: ____AGE:_________ D.O.B: _______________
NAME: ____AGE:_________ D.O.B: _______________

PERSON(S) BRINGING YOUR CHILD IN YOUR ABSENCE
NAME: ____
PHONE:_______________________ HOW RELATED:____
NAME: ____
PHONE:_______________________ HOW RELATED:____
ADITIONAL CONTACTS / EMERGENCY CONTACT IN THE EVENT YOU ARE NOT REACHABLE
NAME:____________________________PHONE:__________________HOW RELATED: _________________
NAME:____________________________PHONE:__________________HOW RELATED: _________________

INSURANCE INFORMATION
NAME OF INSURANCE:______________________________________HMO__PPO__EPO__ MEDICAID __
CONTRACT, ID OR POLICY # : ____________________________ GROUP #:___________________
NAME OF INSURED/POLICY HOLDER :_______________________________ D.O.B: __________________
RELATIONSHIP TO PATIENT: ____

PHARMACY NAME: ________________________________ PHONE: _______________________________
ADDRESS: ____