Salud Pediatrics Registration

Family Name:	Home Address:
Home Number: Cell Number	City: State: Zip:
Preferred Pharmacy Name: Pharmacy Location:	*Required by government mandate [although you may refuse)* Language: Ethnicity:
PATIENT NAMES	
First Born:	DOB: M F
Second Born:	DOB: M F
Third Born:	DOB: M F
PARENTS / GUARDIANS	
Parent 1 Name:	Parent 2 Name:
Parent 1 Email:	Parent 2 Email:
Parent 1 Cell:	Parent 2 Cell:
How would you prefer to be reached?	Cell SMS Email All
INSURANCE	
Insurance Name:	Policy Holder DOB:
Policy Holder Name:	Policy Holder's Employer:
Effective Insurance Date:	
ACKNOWLEDGEMENT AND AUTHORIZATION	
I have read and understood the HIPAA/Privacy Policy for Salud Pediatrics	
I hereby assign my insurance benefits to be paid directly to the healthcare provider	
I authorize Salud Pediatrics to release medical information required to process my child's claim	
I have read and understood the Parent Agreement for Salud Pediatrics	
I authorize Salud Pediatrics to contact me by mobile phone	
Name: Signature:	
Relationship to the Patient: Date:	