ACCT #_____

PATIENT INFORMATION SHEET

PATIENT'S LAST NAME:_____**FIRST:**_____**M.I**____

NICKNAME:_____ SEX: M__F__ D.O.B: __/__/__ SSN#:___-___-____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____ COUNTY:____

HOME PHONE #:( )____-_____ NAME OF CHILD'S PREVIOUS DR:_____
(PLEASE ASK RECEPTIONIST FOR TRANSFER OF RECORDS REQUEST FORM)

RESPONSIBLE PARTY FOR SERVICES: (Please list one individual patient is living with)

LAST NAME:_____FIRST:_____ M.I.:____

RELATIONSHIP TO PATIENT:_____ D.O.B.: ___/___/___ SSN#:____-___-____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____ COUNTY:____

HOME PHONE #:( )_____-_____ WORK #:( )_____-_____ EXT:_____

EMPLOYER:_____
****

FATHER'S NAME:_____ D.O.B. ___/___/___ SSN#:____-____-____
FATHER'S PHONE # AND ADDRESS (if different than responsible party) ( )____-_____

FATHER'S EMPLOYER:_____ PHONE #: ( )_____-_____

MOTHER'S NAME:_____ D.O.B. ___/___/___
MOTHER'S PHONE # AND ADDRESS (if different than responsible party) ( )_____-_____

MOTHER'S EMPLOYER:_____ PHONE #: ( )_____-_____

IN case of Emergency notify:_____ Phone #: ( )_____-_____
(please list someone other than parent/guardian)
Relationship to patient:_____

PHARMACY INFORMATION:
YOUR PHARMACY:_____ PHONE #: ( )_____-_____

OTHER CHILDREN:
NAME (LAST) (FIRST) (MI) (D.OB.) (SEX)

(OVER)

REFERRED BY:_____

INSURANCE INFORMATION:

IS THE PATIENT COVERED UNDER A HEALTH CARE PLAN? YES_____ NO_____

If "YES" please check with your insurance and our office to make sure that we are listed as a provider and that we are currently accepting enrollment with this healthcare plan in our office. You will need to provide the office with a ***current copy of the medical ID card. WITHOUT THE MEDICAL ID CARD,WE WILL BE UNABLE TO FILE ANY MEDICAL CLAIMS FOR THE PATIENT AND, PAYMENT IN FULL WILL BE REQUIRED AT THE TIME OF THE SERVICES PROVIDED.***

I understand that if I carry an HMO insurance policy that as a member it is my responsibility to be sure that the patient listed has been assigned to Dr. Hassan H. Youssef MD, Dr. Carolyn Rivera Garcia MD as a primary care physician (PCP).

I understand that my insurance benefits have not been verified for medical coverage or eligibility. It is understood that if any services rendered to the patient is not covered by the patient's insurance policy, the charges for such services will be the responsibility of the patient (Responsible Party)

I understand that it is the policy of the office that if I am unable to make the scheduled appointment that I will give a 24-hour notice if at all possible. Failure to call more than once could result in a $15.00 failure charge and even up to dismissal from the medical practice.

I understand that in the event I am unable to bring my own child I have to send a signed and dated note giving the office permission to give treatment to my child in my absence, with the person that is bringing the child.

DATE:_____ SIGNATURE:_____

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to the physician and am financially responsible for non-covered services. I also authorize the physician to release any information required in processing of medical claims. Further more, I understand that the physician will not accept the Medical Card if there is a balance due on the patients account.

DATE:_____ SIGNATURE:_____

DATE:_____ WITNESS:_____