0Divino Niño Pediatrics, PLLC
REGISTRATION FORM

Today's date:	PCP: Denise Nuñez, MD

PATIENT INFORMATION

Patient's last name:	First:	M	Social Security No:

Home Phone No.	Cell Phone No:	Birthdate: / /	Age:		Sex: ❑ M ❑ F
Street address:		Apt #			
City:	State:	Zip Code:	**Pharmacy:**		

MOTHER OR LEGAL GUARDIAN INFORMATION

Last Name:	First Name:	SS#	**Email:**
Address:	Home Phone:	DOB:	Occupation:

FATHER OR LEGAL GUARDIAN INFORMATION

Last Name:	First Name:	SS#	Email:
Address:	Home Phone:	DOB:	Occupation:

How did you hear about us? __ Healow ___ Social Media __ ZocDoc __ Friend/family __ Flyers

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Cell phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Insurance Company Name:	Group No:	Policy No:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Divino Nino Pediatrics. I understand that I am financially responsible for any balance. I also authorize Divino Nino Pediatrics or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*