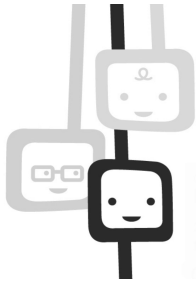

Cordero, Perez-Silva & Rodriguez, MD PA
2700 SW 3 Avenue, Suite 1-F
Miami, Florida 33129
Tel: (305) 285-2574
Fax: (305) 285-5505

Language spoken: ______________

PATIENT REGISTRATION
(PLEASE COMPLETE ENTIRE FORM)

Name of Patient ____________________________________ **DOB** __________________ **Sex** □ **M** □ **F**

Race___________________ **Child's SSN** _____________________

Mother's Information

Name ______________________________ DOB ______________ SSN _______________ Rel. to Pt. ____________

Address ____________________________ City _______________ State _______________ Zip __________________

Telephone (home) ________________________ (work) __________________________ (cell) _______________________

Employer _____________________________________ Occupation ____

Father's Information

Name ______________________________ DOB ______________ SSN _______________ Rel. to Pt. ____________

Address ____________________________ City _______________ State _______________ Zip __________________

Telephone (home) ________________________ (work) __________________________ (cell) _______________________

Employer _____________________________________ Occupation ____

Emergency Contact Information

Name ______________________________ Rel. to Pt. ________________________ Phone ________________________

Primary Insurance

Company Name _______________________ Group Number ________________ Policy Number __________________

Policy Holder __________________________________ DOB ________________ Rel. to Pt.______________________

Secondary Insurance

Company Name _______________________ Group Number ________________ Policy Number __________________

Policy Holder __________________________________ DOB ________________ Rel. to Pt.______________________

Medicaid Information (if applicable)

Medicaid Number ________________________________ Mother's Maiden Name ________________________________

Sibling Information

Name ____ DOB ________________ Lives at home __________________

Name ____ DOB ________________ Lives at home __________________

Name ____ DOB ________________ Lives at home __________________

Signature ____ Date ___________________________________
(Parent/Guardian if patient is a minor)