



Eduardo Diaz, MD PA  
5703 NW 7 th St. Miami, Fl 33126  
Ph: (305) 267- 3462 / fax: (305) 267-3463

**PATIENT REGISTRATION  
REGISTRO DEL PACIENTE**

Acct #: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
(Nombre del paciente) (Fecha de nacimiento) (Edad)

**Patient's SSN:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_  
(Seguro Social) (Sexo) (Raza)

**Address:** \_\_\_\_\_  
(Direccion)

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_  
(Ciudad) (Estado) (Codigo Postal) (Correo electronico)

**Home Telephone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_  
(Telefono de la casa) (Celular)

**Family Preferred method of communication (Check one):** Ph: \_\_\_\_\_ E-mail: \_\_\_\_\_ Mail: \_\_\_\_\_  
(Metodo de comunicacion Preferido) (Marque uno)

**Preferred Language:** \_\_\_\_\_ **Pharmacy Ph:** \_\_\_\_\_  
(Idioma de preferencia) (# de farmacia)

**Mother's Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_  
(Nombre de la madre) (# de seguro social)

**Employer's Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_  
(Nombre del empleador) (Telefono)

**Father's Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_  
(Nombre del padre) (# de seguro social)

**Employer's Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_  
(Nombre del empleador) (Telefono)

**Emergency Contact:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_ **Rel. to Pt.:** \_\_\_\_\_  
(Contacto de Emergencia) (Telefono) (Relacion con el paciente)

**Primary Insurance:** \_\_\_\_\_ **Insurance ID:** \_\_\_\_\_  
(Seguro Primario) (Numero de Membresia)

**Policy Holder:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Rel. to Pt.** \_\_\_\_\_  
(Nombre del Asegurado Principal) (Fecha de Nac.) (Relacion con el paciente)

**Secondary Insurance:** \_\_\_\_\_ **Insurance ID:** \_\_\_\_\_  
(Seguro Secundario) (Numero de Membresia)

**Policy Holder:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Rel. to Pt.** \_\_\_\_\_  
(Nombre del Asegurado) (Fecha de Nacimiento) (Relacion con el paciente)

All office fees are to be paid at the time services are rendered. Your medical Insurance is a contract between you and your insurance company, whose payments for our services vary according to the terms of your policy. Final payment of all charges is the patient's responsibility. I hereby authorize payment directly to **Eduardo Diaz, MD PA (AKA Dr. Diaz Pediatrics)** of all benefits applicable, if any, and otherwise payable to me for services rendered. I understand I am responsible to **Eduardo Diaz, MD PA** for charges not covered by this assignment. I authorize release of information to all my insurance companies. I authorize use of this form on all my insurance submissions. I permit a copy of this authorization to be used in place of the original. The undersigned consents to treatment of the patient under the doctor's medical advise.

\_\_\_\_\_  
**Patient/ Parents Signature**  
**Firma del Paciente/Padre/Madre**

\_\_\_\_\_  
**Date/ Fecha**