CARLOS ORTIZ MD PC
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PATIENTS' INFORMATION (MANDATORY) ***Please read the HIPPA form***

Patients' Complete Legal Name:	Circle one: Male Female
Patients' DOB: _____/_____/_____ Month / Day / Year	Patients' Social Security #:
Patients' Siblings: #1 Name: _____ DOB: _____/_____/_____ #2 Name: _____ DOB: _____/_____/_____	
Home Address: **No Post Office** _____ _____	
Telephone #s: (Can be a cell number) **Must have a minimum of one contact number**	
Mother's #: (_____) _____-_____	*Mother's Work #:* (_____) _____-_____
Father's #: (_____) _____-_____	Father's Work #: (_____) _____-_____

INSURANCE INFORMATION

The following information is needed for identification and insurance purposes. Everything must be completed. Caretakers are responsible for accuracy and for up to date information. If the patient does not have insurance, we need parents' full name and date of births. If parent is not listed, we will not release information to that parent.

Guarantor # _____ What Insurance is effective as of today? _____

Who is the primary insured? _____ Father or Mother?

Father's Full Legal Name	**Father's DOB** _____/_____/_____ Month / Day / Year
Father's Social Security #	**Father's Email**
Name of Insurance Carrier:	
Mother's Full Legal Name	**Mother's DOB** _____/_____/_____ Month / Day / Year
Mother's Name as listed on the birth certificate:	
Mother's Social Security #	**Mother's Email**
Name of Insurance Carrier:	

If there is a recent change of address, telephone numbers, insurance, or primary insured, please circle: Yes or No

PLEASE READ BEFORE SIGNING: To my knowledge, all the information provided by me on this form is both accurate and up to date. I know that I am solely responsible for any fraudulent or misleading information.

_____ Print Full Name

_____ Relationship to Patient (Mother/ Father/ Other)

_____ Legal Signature

_____/_____/_____ Today's Date