

PAT RICALDE, DDS, MD, FACS

Patient Name: _____	DOB: ____/____/____ SS# ____-____-____
Address: _____	Apt# _____ Phone# _____
City: _____ State: _____ Zip: _____	Cell# _____
Sex: Male _____ Female _____ Email: _____	Referring Physician: _____
Referring Physician Phone# _____	Pharmacy _____
Pharmacy Phone: _____	Dentist: _____
Orthodontist: _____	Pediatrician/PCP: _____

Who has legal Custody of the Patient: ()Parents ()Mother Only () Father Only () Foster Parent () Grandparent () HRS/Other
****IF NOT BIOLOGICAL/NATURAL PARENTS, COURT DOCUMENTS MUST BE PRESENT AT TIME OF VISIT****

Mother's name: _____ SS#: ____-____-____ DOB: ____/____/____ Address: _____ (if different from child's) City: _____ State: _____ Zip: _____ Home #: (____) ____-____ Cell#: (____) ____-____ Work #: (____) ____-____ Employer: _____	Father's name: _____ SS#: ____-____-____ DOB: ____/____/____ Address: _____ (if different from child's) City: _____ State: _____ Zip: _____ Home#: (____) ____-____ Cell#: (____) ____-____ Work#: (____) ____-____ Employer: _____
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Emergency Contacts

#1. Name: _____	Relationship: _____	Phone#: (____) ____-____
#2. Name: _____	Relationship: _____	Phone#: (____) ____-____

Insurance Information

Primary Insurance	HMO	PPO	POS	OTHER	Secondary Insurance	HMO	PPO	POS	OTHER
Insurance Carrier: _____					Insurance Carrier: _____				
Policy# _____ Group# _____					Policy# _____ Group# _____				
Policyholder's Name: _____					Policyholder's Name: _____				
Date of Birth _____					Date of Birth _____				
Relationship to patient: _____					Relationship to patient: _____				

ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to Florida Craniofacial Institute the surgical and/or medical benefits, if any, otherwise payable to me for services described on the attached claim, but not to exceed the charges for the service. If my health insurance plan will not direct payment to Florida Craniofacial Institute, I agree to forward all health insurance payments I receive for the services rendered by Florida Craniofacial Institute upon receipt of such payments.

Parent/Guardian Signature _____ Date _____