PATIENT HISTORY INFORMATION

Belkys Bravo, M.D., F.A.A.P.
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www.belkysbravomd.com

MOTHER / GUARDIAN: ______________________ D.O.B.: ______________

Maiden Name: ______________________ S.S. # ______________

Permanent Address: ______________________________________

City: ______________ State: ______________ Zip: ______________

Nationality: ______________________ Home Phone: ______________

Place of employment: ______________________ Occupation: ______________

Work Phone: ______________ e-mail: ______________ Cell phone: ______________

FATHER / GUARDIAN: ______________________________________

D.O.B.: ______________________ S.S. # ______________

Permanent Address: ______________________________________

City: ______________ State: ______________ Zip: ______________

Nationality: ______________________ Home Phone: ______________

Place of employment: ______________________ Occupation: ______________

Work Phone: ______________ e-mail: ______________ Cell phone: ______________

Primary Insurance: ______________________ **Policy Number:** ______________

Group Number: ______________________________________

CHILDREN

Name:	**D.O.B.**	**Sex**

1. All office fees are to be paid at the time services are rendered or charged to Visa or Mastercard.
2. 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 to Belkys Bravo M.D., of all benefits applicable and otherwise payable to me from my insurance carrier, PPO, HMO, or any 3rd party payer. I understand I am responsible to Dr. Bravo for charges not covered by this assignment for any charges the carrier declines to pay. I authorize the release of my children's medical records as deemed necessary.

The Undersigned consents to treatment of the patient under the doctor's medical advice:

Mother/Guardian: ______________________ **Father/Guardian:** ______________________

Date: ______________________ **Date:** ______________________