REGISTRATION FORM

Advanced Pediatrics PC
Gonzalo Sabogal MD/Wilfredo Lao MD
94-36 59 Ave Suite C4
Elmhurst, NY 11373

Patient_____
Last Name First Name M.I

Sex F M Date of Birth_____

Address_____Apt#_____

City_____State_____Zip Code_____

Home Phone:_____Business #_____

Emergency Contact:_____Phone:_____

Email: _____

Parents/Guardian:_____

Sex: M F Date of Birth_____

Insurance: _____ Policy: _____

Assignment and Release
I hereby authorize Dr.Lao / Dr.Sabogal to examine my Son/Daughter.

_____ _____
Signature of Guardian Date

I, the insured, have insurance coverage with_____
And assign directly to Dr.Lao/Dr.Sabogal all the medical benefits, if any otherwise payable to me for the service rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctors to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Guardian Date