

REGISTRATION FORM

Advanced Pediatrics PC
Gonzalo Sabogal MD/Wilfredo Lao MD
40 35 95 Street
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