WEST KENDALL OBGYN

Last Name/Apellido_____ **First Name/Nombre**_____ **M.I**_____

Social Security Number_____ **DOB/Fecha de Nacimiento**_____

Home Address/Dirección_____ **City**_____ **State**_____

Zip Code/Código Postal_____ **Email**_____

Home Phone/Teléfono_____**Work/Trabajo**_____ **Mobile**_____

Marital Status/Estado Civil_____ **Race/Raza**_____ **Ethnicity/Origen Étnico**_____

PRIMARY DR. / MEDICO PRIMARIO:_____**Phone/Telefono**_____

Name & Phone Number of an Emergency Contact
Nombre y Teléfono de un Contacto de Emergencia:_____

Pharmacy/Farmacia_____**Phone/Telefono**_____

Pharmacy Location/Dirección de Farmacia_____

Primary Insurance/ Seguro Primario_____

Member ID/Numero de Membrecía_____**Group #/Numero de Grupo**_____

Insurance Billing Address/Dirección de Seugro_____

Insurance Phone Number/Teléfono de Seguro_____

Name of Insured/Nombre de Asegurado_____**SS#**_____

DOB/Fecha de Nacimiento_____ **Relationship to Patient/Relación con el Paciente**_____

***PLEASE READ: ALL charges are due at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claims forms to the office prior to hospitalization.**

I hereby authorize payment of medical benefits billed to my insurance by Florida Woman Care. I hereby accept responsibility for payment of any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if the practice does not participate with my insurance. I agree to pay all co-payments, co-insurance, and deductibles at the time that services are rendered.

Signature/Firma_____ **Date/Fecha**_____

KENDALL
ONE SEVENTEEN PROFESSIONAL ARTS CENTER
8200 SW 117TH AVE, SUITE 304, MIAMI, FL 33183
T: 305.226.5651 F: 305.226.2424

WEST KENDALL
WEST KENDALL BAPTIST MEDICAL ARTS BLDG
15955 SW 96TH ST, SUITE 304, MIAMI, FL 33196
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