

*"Bringing Old-Fashioned Medicine Back Home"*

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### Patient Demographic Form

#### Patient Information

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security# \_\_\_\_\_ Male Female (Please circle)

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Home Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Contact email address \_\_\_\_\_

Mother's Cell Phone \_\_\_\_\_ Father's Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

How did you hear about us? Name \_\_\_\_\_ Website Facebook Twitter Seminar(Please circle)

#### Patient's Insurance Information

PRIMARY Insurance Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: Parent Self Other \_\_\_\_\_ (Please circle)

#### Pharmacy Information

#### Emergency Contact Information:

Name \_\_\_\_\_ Name \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Fax \_\_\_\_\_ Alternate Phone \_\_\_\_\_

#### Assignment of Benefits- Financial Agreement

*I authorize and request my insurance company to pay benefits otherwise payable to me directly to Personalized Pediatrics; I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.*

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

(Parent's signature if patient is under 18)

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