



Little Buddies Pediatric Clinic

Dr. Luis A. Lopez, MD.



Patient Information (All Information Is Required)

Patient Name (F,M,L): Preferred Name (If different from given name):
Gender: M F Date of Birth: Social Security #:
Home Address: Apt #: City: State: Zip:

Parent/Guardian Information (All Information Is Required)

1. Name (F,M,L): Relationship to Patient: Date of Birth:
Social Security #: Driver's License #: State:
Address (If different from above): City: State: Zip:
Email Address: Cell Phone #:
Employer: Preferred Contact: Email Cell

2. Name (F,M,L): Relationship to Patient: Date of Birth:
Social Security #: Driver's License #: State:
Address (If different from above): City: State: Zip:
Email Address: Cell Phone #:
Employer: Preferred Contact: Email Cell

Emergency Contact Information (All Information Is Required)

Name (F,M,L): Relationship to Patient:
Cell Phone #:

Insurance Information (All Information Is Required)

Insurance Company Name: Insurance Phone #:
Insurance ID #: Group #: Benefit Code:
Effect Date: Insured Name: Date of Birth:
Social Security #: Relationship to Patient:

Unfortunately at the time we are not accepting Secondary Insurance. Also, if insurance benefits cannot be verified at the time of service you have the option to be self-pay or reschedule the appointment. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Preferred Language: Spanish  English

In accordance with the Affordable Care Act, please select the patient's race and ethnicity:

- |   |  |
|---|--|
| Race: <input type="checkbox"/> White                  | Ethnicity: <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Black                        | <input type="checkbox"/> Not Hispanic or Latino        |
| <input type="checkbox"/> Asian                        | <input type="checkbox"/> Decline to Answer             |
| <input type="checkbox"/> American Indian              |  |
| <input type="checkbox"/> Hawaiian or Pacific Islander |  |
| <input type="checkbox"/> Decline                      |  |

**Assignment of Benefits/Financial Agreement Information (Required)**

I authorize payment of insurance benefits to be made directly to Dr. Luis A. Lopez, and any assistant physicians for services rendered. I understand that I am financially responsible for all charges whether or not it is covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this health care provider to release the necessary information to secure the payment of benefits. I further agree that a photo copy/scanned copy of this agreement shall be as valid as the original.

Do you grant us permission to submit vaccine information to the local immunization registry?

Please check off one: Yes  No

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date