Elsa G. Brieno, MD

Patient Information (Please print and fill out all information)

Name (First Middle Last)			Date of Birth	Age	Sex
Address	City	State	Zip	Phone #	
Birth Hospital & Birth Weight		Problems at Birth			
Past Illnesses & Hospitalizations		Allergies		Pharmacy	
History of Family Illnesses		List Medications taken			
List Brothers & Sisters And Dates of Birth					
Race: __American Indian or Alaska Native __Asian __Black or African American __Pacific Islander __White __Elect not to disclose		Ethnic Group: __Hispanic __Non Hispanic __Elect not to disclose			
Primary Language: __English __Spanish __Asian __Other		Parent's primary email address:			

Responsible Party

Father's Name	Date of Birth	Social Security Number
Place of Employment	Position	Work Number
Mother's Name	Date of Birth	Social Security Number
Place of Employment	Position	Work Number

Emergency Notification

Name of Person	Relationship To Patient	Phone Number

Insurance Information

Insurance Company	Group Number	Member Id
Insurance Address		Insurance Phone #
Policy Holder Name	Date of Birth	Employer

AUTHORIZATION: I hereby authorize Assignment of Insurance Benefits to Elsa G. Brieno, M.D. I acknowledge that I am responsible for payment of services provided but not covered by my health plan. I authorize the doctors to release Medical Records and other information to requesting Insurance companies. I acknowledge responsibility for payment of lab services provided by outside lab services. I acknowledge responsibility for referral procedures and payments to specialist and other healthcare professionals.

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Signature Date