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: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____ Ext: _____

Preferred Phone: Home☐ Cell☐ Work☐ Employer: _____

Email Address: _____

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: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____ Ext: _____

Preferred Phone: Home☐ Cell☐ Work☐ Employer: _____

Email Address: _____

Emergency Contact Information (All Information Is Required)

Name (F,M,L): _____ Relationship to Patient: _____

Home Phone #: _____ 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: ☐ White
☐ Black
☐ Asian
☐ American Indian
☐ Hawaiian or Pacific Islander
☐ Decline

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline to Answer

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