

Children's Medical Center

Theodore Morrison, M.D.
Rachel Cyrlak, M.D.
Mitchell J. Samuels, D.O.
Jacinta C. Magnus, M.D.

Kenneth J. Budowsky, M.D.
Enrique T. Gonzalez, M.D.
Nancy Chiang, M.D.

Lisa Gwynn, D.O.
Henry Levine, M.D.
Dionne Skervin, M.D.

Christine Colucci, ARNP
Jennifer Rector, ARNP
Carol Beloff, ARNP

Welcome to Children's Medical Center. We look forward to providing the best pediatric care for your child.

Attached you will find forms to be completed prior to your scheduled appointment. Please bring the completed forms, along with your child's insurance card and immunization record, to the first visit.

You can also fax the forms to the office of your appointment.

If your appointment is scheduled at:

Please fax forms to:

4651 Sheridan St, Hollywood, FL

(954) 967-8962

12251 Taft Street, Pembroke Pines, FL

(954) 435-7185

20170 Pines Blvd, Pembroke Pines, FL

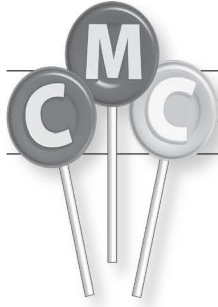
(954) 378-1530

We will verify your insurance information and set up your chart prior to the appointment, to make your visit more accommodating.

Should you have any questions, please call our office directly.

Thank you and see you soon!

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| New Patient Name(s) LEGAL NAME ONLY | Social Security# | Sex | Date of Birth | Birth Weight |
|--|------------------|-----|---------------|--------------|
| | | | | |
| | | | | |
| | | | | |

Are there any siblings that are established patients at Children's Medical Center? Y / N (if Yes, what is the name?) _____

Father/Guardian _____

Mother/Guardian _____

SS# _____ DOB _____

SS# _____ DOB _____

Driver's License # _____

Driver's License # _____

e-mail address _____

e-mail address _____

Address _____

City _____ State _____ Zip Code _____

Marital Status _____ Major languages spoken at home _____ Physician _____

Home Telephone # _____

Cell Phone # _____

Financial Responsibility (if different than above) _____ Relationship to patient _____

Address _____

City _____ State _____ Zip Code _____

Father's Employer _____

Mother's Employer _____

Address _____

Address _____

Work # _____

Work # _____

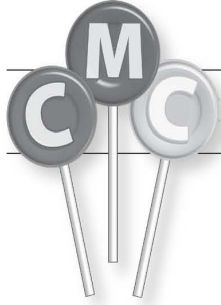
Emergency Contact Name (other than Parents) _____

Phone _____ Relationship _____

Services rendered are charged to the Patient and not to Insurance Company. Therefore we cannot accept an insurance form payment on your account. Payment is due upon the receipt of services. We will be happy to assist you in the filing of your insurance forms. If collection becomes necessary, the Undersigned shall pay all costs, including attorney's fees.

Signature _____

Date _____



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INSURANCE INFORMATION

_____ Regular Insurance _____
Name of Insurance

_____ PPO Insurance _____
Name of Insurance

_____ HMO Insurance _____
Name of Insurance

Primary Insured Name _____

Date of Birth _____

Policy # _____

Group # _____

Effective Date _____

SS# (of Policyholder) _____

Co-Payment \$ _____

Deductible (if any) \$ _____

Co-Insurance (if any) _____ %

Secondary Insurance (if applicable) _____

Insured Name _____

Date of Birth _____

Policy # _____

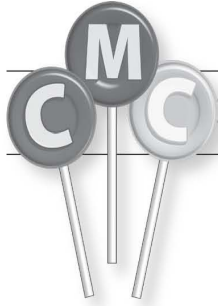
Group # _____

Effective Date _____

SS # (of Policyholder) _____

A copy of your insurance card(s) is necessary to be kept on file. It is a patient's responsibility to notify this office in the event of any information changes. The patient is responsible for any co-payment, deductible, co-insurance and /or any non-covered services.

Signature _____ Date _____



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Guarantor _____

Policy # _____
Primary Insured's Name

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize any Doctor or Hospital who has attended me to give _____
Insurance Company, or its representatives, any and all information, including history records, that may be
deemed necessary by the Company.

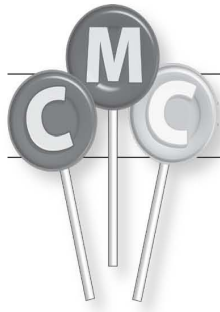
Signature _____
Parent or Legal Guardian

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment to Children's Medical Center, P.A. such payment, as would be otherwise payable
to me. I understand that I am financially responsible to the Doctor for charges not covered by my assignment.

Signature _____
Parent or Legal Guardian

Name of Patients:



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REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ D.O.B. _____

D.O.B. _____

D.O.B. _____

D.O.B. _____

PREVIOUS DOCTOR INFORMATION:

PHYSICIAN/PRACTICE NAME _____

ADDRESS: _____

CITY

STATE

ZIP CODE

I HEREBY REQUEST THAT THE ABOVE PATIENT'S MEDICAL RECORDS BE RELEASED TO:
(CIRCLE ONE)

CHILDREN'S MEDICAL CENTER, P.A.

**20170 PINES BLVD, STE #203
PEMBROKE PINES, FL 33029
PHONE (954) 378-1500
FAX (954) 378-1530**

**12251 TAFT STREET
PEMBROKE PINES, FL 33027
PHONE (954) 435-7000
FAX (954) 435-7185**

**4651 SHERIDAN STREET
HOLLYWOOD, FL 33021
PHONE (954) 989-6000
FAX (954) 967-8962**

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

PRINT NAME: _____

RELATIONSHIP TO PATIENT: _____