

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.

Henry Levine, M.D.
Joerdan Ricketts, M.D.
Dolly Kerin Weisserman, M.D.

Christine Tani, 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

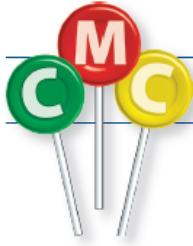
(954) 378-1530

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!

Children's Medical Center, P.A.



Children's Medical Center

Theodore Morrison, M.D. Kenneth J. Budowsky, M.D. Henry Levine, M.D. Christine Tani, ARNP
 Rachel Cyrlak, M.D. Enrique T. Gonzalez, M.D. Joerdan Ricketts, M.D. Jennifer Rector, ARNP
 Mitchell J. Samuels, D.O. Nancy Chiang, M.D. Dolly Kerin Weisserman, M.D. Carol Beloff, ARNP
 Jacinta C. Magnus, M.D.

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 are their names?) _____

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 _____

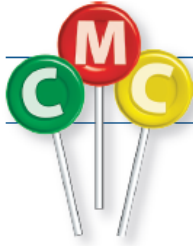
Work # _____ Work # _____

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 as 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 _____



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.

Henry Levine, M.D.
Joerdan Ricketts, M.D.
Dolly Kerin Weisserman, M.D.

Christine Tani, ARNP
Jennifer Rector, ARNP
Carol Beloff, ARNP

INSURANCE INFORMATION

_____ Regular Insurance _____
 _____ PPO Insurance _____
 _____ HMO Insurance _____

Name of Insurance
 Name of Insurance
 Name of Insurance

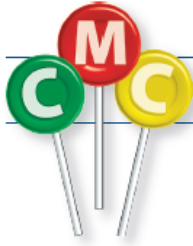
Primary Insured Name _____ Date of Birth _____
 Policy # _____ Group # _____
 Effective Date _____ SS# (of Policyholder) _____
 Co-Payment \$ _____ Deductible (if any) \$ _____ Co-Insurance (if any) _____%

Secondary Insurance (if applicable) _____

Insured Name _____ Date of Birth _____
 Policy # _____ Group # _____
 Effective Date _____ SS # (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 _____



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.

Henry Levine, M.D.
Joerdan Ricketts, M.D.
Dolly Kerin Weisserman, M.D.

Christine Tani, ARNP
Jennifer Rector, ARNP
Carol Beloff, ARNP

Primary Insured's Name: _____

Policy #: _____

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, which may be deemed necessary by the Company.

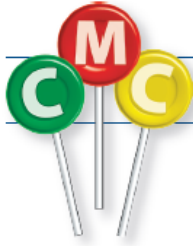
Signature _____
Parent or Legal Guardian

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:



Children's Medical Center

Theodore Morrison, M.D. Kenneth J. Budowsky, M.D. Henry Levine, M.D. Christine Tani, ARNP
 Rachel Cyrlak, M.D. Enrique T. Gonzalez, M.D. Joerdan Ricketts, M.D. Jennifer Rector, ARNP
 Mitchell J. Samuels, D.O. Nancy Chiang, M.D. Dolly Kerin Weisserman, M.D. Carol Beloff, ARNP
 Jacinta C. Magnus, M.D.

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)

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

**CHILDREN'S MEDICAL CENTER, P.A.
 12251 TAFT STREET, #201
 PEMBROKE PINES, FL 33027
 PHONE (954) 435-7000
 FAX (954) 435-7185**

**4651 SHERIDAN STREET, #270
 HOLLYWOOD, FL 33021
 PHONE (954) 989-6000
 FAX (954) 967-8962**

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

PRINT NAME: _____

RELATIONSHIP TO PATIENT: _____