CINCO WEST PEDIATRICS

Raquel M. Sagullo, MD, FAAP

Cinco West Pediatrics is dedicated to providing the best, evidenced-based medicine for our patients. In order to do this, a partnership based on respect and mutual trust must exist. We believe that immunizations are one of the most important health recommendations we can make on behalf of our patients. This is a life-saving intervention, and we want all of our patients to benefit from it.

We understand and respect the parents' role as the ultimate decision-makers for their child's care, but we are obligated to deliver the best and safest healthcare for the patient and our community. Our physicians subscribe to the vaccine schedule established by the American Academy of Pediatrics and the CDC, and we ask that you vaccinate your child according to this schedule.

If you do not plan to follow the immunization schedule, this may not be the right pediatrics practice for you. If you *do* plan to follow our recommended immunization schedule, please sign and date below.

Signature: _____

Date: _____

Patient's Name: _____

Sibling: _____

Sibling: _____

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Cinco West Pediatrics
Patient Registration

Today's Date _____

Patient Information:

_____ _____ _____
First Middle Last Date of Birth Gender M F

Siblings:

_____ _____ _____
First Middle Last Date of Birth Gender M F

_____ _____ _____
First Middle Last Date of Birth Gender M F

Address_____ City _____ State ____ Zip _____

Telephone number_____

How did you hear about us? _____

Demographic

Race_____
Preferred Language_____

Parent/Guardian Information

Father's Name: _____ Mother's Name: _____

Date of Birth: _____ Date of Birth: _____

Occupation: _____ Occupation:_____

Home Phone: _____ Home Phone: _____

Cellular Phone: _____ Cellular Phone: _____

Work Phone: _____ Work Phone: _____

Email: _____ Email: _____

Policy Holder Information:

Primary Insurance Name _____

Policy Holder Name _____

Date of Birth _____

Emergency Contact 1 Name _____ Contact #_____

Emergency Contact 2 Name_____ Contact #_____

PharmacyName Address Phone number

_____

Assignment of Benefit

I hereby authorize direct payment of medical/surgical benefits to
Raquel M Sagullo MD, PLLC dba Cinco West Pediatrics for services rendered by herin person or under her supervision.
I understand that I am financially responsible for any balance not covered by my insurance.

Any services rendered outside of the clinic, i.e. lab work, blood tests, x-rays, ER visits, urgent care visits etc.,that are not covered by insurance will be my financial responsibility.

Authorization to Release Information

I hereby authorize Dr. Raquel Sagullo to release any medicalor incidentalinformation that may be necessary for either medical care or in processing applications for financial benefit.

Consent to Treat

Patient's parent or guardian or designee is giving permission to the doctors,nurses, medical assistants, and other health care providers in this office toprovide treatment for the patient.

Signature of Patient or Patient's Representative:_____

Date Signed:_____