PATIENT NAME {LAST, FIRST, MIDDLE}:	DATE OF BIRTH:	GENDER:
1)_____	_____	M / F
2)_____	_____	M / F
3)_____	_____	M / F
4)_____	_____	M / F
5)_____	_____	M / F

MOTHER'S NAME: _____ **DOB:**_____

ADDRESS:_____ **APT:**_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

EMAIL:_____

EMPLOYER:_____**OCCUPATION:**_____

PHONE#:_____**ETHNICITY:**_____

FATHER'S NAME: _____ **DOB:**_____

ADDRESS:_____ **APT:**_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

EMAIL:_____

EMPLOYER:_____**OCCUPATION:**_____

PHONE #:_____**ETHNICITY:**_____

– – – – – – – – –

INSURANCE CO:_____ **MEMBER ID#:**_____

SUBSCRIBER NAME & RELATION TO PATIENT:_____

PATIENT'S EMERGENCY CONTACT/PHONE #:_____

HOW DID YOU FIND US?_____

As a Parent or Legal Guardian, I give permission to Mar and Sea Pediatric to treat the patient(s) listed above. I agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I understand that I am responsible for any co-payments and/or non-covered insurance charges. I also authorize the release of medical information necessary for the processing of insurance claims. Please sign below signifying that you have read and understand the above statement and that thus the office has permission to submit insurance claims.

PRINT NAME OF PARENT OR GUARDIAN:_____

SIGNATURE:_____ **DATE:**_____

DR. MARIA MARGARITA ARREAZA, M.D.
14000 S. MILITARY TRAIL SUITE #106
DELRAY BEACH FL, 33484
P: 561-270-5144 F: 561-450-7599 E: Faxmarandsea@gmail.com

RELEASE OF MEDICAL RECORDS TO MAR AND SEA PEDIATRIC

I, _____ do hereby authorize the release of medical records for my child_____ whose date of birth is _____ to the office of Maria Arreaza M.D. **Mar and Sea Pediatric**.

If more than one patients:

Patient Name: _____ Date of Birth:_____
Patient Name: _____ Date of Birth:_____
Patient Name: _____ Date of Birth:_____
Patient Name: _____ Date of Birth:_____

Please email or fax records to:

ATTN: Medical Records
FAX#: 561-450-7599
FAXMARANDSEA@GMAIL.COM

This signature below serves as authorization to transfer the records.

Signature: _____ Relationship to Patient:_____

Date:_____

Release:
( ) All records
( ) Scans (X-ray, blood work, or lab results)
( ) Other:
_____

Vaccination Disclosure:

Dear Parent or Guardian,

Vaccinations are a crucial aspect of pediatric care. We strongly recommend and support vaccinations as part of the recommended immunization schedule. However, we respect the diversity of our patients and understand that some families may have religious or personal reasons to opt out of vaccinations.
For families who choose not to vaccinate, we will continue to offer the best care and support while maintaining a safe healthcare environment. We will ensure unvaccinated children receive the care they need. **
Parent/Guardian Initials: _____

Mar and Sea Pediatrics providers will administrate vaccinations to their patients accordingly. The cost of the vaccinations and visit will be submitted to the patient insurance company ONLY if insurance is accepted at our facility. In case the patient's insurance company does not take charge or does not cover it fully. The balance will be the patient's parent or guardian responsibility to fulfill the payment or pay the difference of the vaccines provided.

In the case we do not take your insurance, you will also be offered the self pay prices.

For our SELF PAY patients, the cost of each vaccine is $25 + the visit cost.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient's Parent/Guardian Name: _____

Patient's Parent/Guardian Signature: _____Date: _____

** I DO NOT VACCINATE MY CHILD Parent/Guardian Initials: _____