LUIS A. GHIGLINO, M.D. F.A.A.P.
5962 BERRYHILL ROAD
MILTON, FL 32570
(850) 983-3700

Patient Registration/Confidential

Date Today:_____

Patient's Name_____ M__F__ Date of Birth:_____

Address:_____City:_____State:____Zip:_____

Phone(H):_____ (C)_____Patient's SSN:_____

EMAIL:_____

Mother's Name:_____DOB:_____SSN:_____

Occupation:_____Employer:_____WK#_____

Father's Name:_____DOB:_____SSN:_____

Occupation:_____Employer:_____WK#_____

Guardian's Name:_____DOB:_____SSN:_____

Occupation:_____Employer:_____WK#_____

Emergency Contact:_____**Phone**:_____

No Show Policy:

A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "No Show". A letter will be sent to patients who do not show up for their schedule appointment. We incur the cost of dedicated providers and staff to provide schedule appointments. We understand that there are legitimate reasons for a missed appointment, however if three such events occur in your chart we may ask you to find a new provider.

We request that cancellations be made as early as possible, and preferably 24 hours in advance, so that we are able to schedule another patient in the appointment block

PERMISSION FOR TREATMENT

I hereby, give permission for DR.LUIS A. GHIGLINO to provide medical/surgical treatment to my child/children. I understand by signing this form, I confirm all information is correct, to the best of my knowledge.

Date_____ **Signature**_____
(Parent or Guardian)

Date_____ **Witness**_____

LUIS A. GHIGLINO, M.D. F.A.A.P.
5962 BERRYHILL ROAD
MILTON, FL 32570
(850) 983-3700

BILLING INFORMATION AND RESPONSIBLE PARTY

Billing Name:_____Relation to Patient_____

Billing Address:_____

INSURANCE INFORMATION:

Primary Insurance_____Phone#_____ID#_____
Address_____Group#_____

Name of Insured_____Relation to Patient_____Effective Date____

Secondary Insurance_____Phone#_____ID#_____
Address_____Group#_____

Name of Insured_____Relation to Patient_____Effective Date____

Medicaid #(if applicable)_____

PERMISSION FOR ASSIGNMENT OF INSURANCE

I authorize and direct payment of surgical/medical benefits to **DR. LUIS GHIGLINO** for services rendered by him/her in person or under his/her supervision. **I understand that I am financially responsible for any balance not covered by my insurance. NOTE: IF YOUR CHILD'S ACCOUNT IS TURNED TO A COLLECTION AGENCY DUE TO NON PAYMENT, for whatever reason, WE WILL NO LONGER SEE YOUR CHILD NOR ANY SIBLINGS.**

Date_____ **Signature**_____
(Parent or Guardian)

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize DR. LUIS A. GHIGLINO to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Date_____ Signature_____
(Parent or Guardian)

MEDICAID (if applicable)

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Date_____ Signature_____
(Parent of Guardian)