

**PATIENT HISTORY
INFORMATION FORM**

Dr. Belkys Bravo, M.D., F.A.A.P.
Dr. Roxanna G. Santana, M.D., F.A.A.P.

MOTHER/GUARDIAN: _____ D.O.B.: _____

Maiden Name: _____ S.S. # _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Nationality: _____ Home Phone: _____

Place of employment: _____ Occupation: _____

Work Phone: _____ e-mail: _____ Cell phone: _____

FATHER/GUARDIAN: _____

D.O.B.: _____ S.S. # _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Nationality: _____ Home Phone: _____

Place of employment: _____ Occupation: _____

Work Phone: _____ e-mail: _____ Cell phone: _____

Primary Insurance: _____ Policy Number: _____

Group Number: _____

CHILDREN

Name:	D.O.B.	Sex
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I Hereby authorize payment to Belkys Bravo M.D., of all benefits applicable and otherwise payable to me from my insurance carrier, PPO, HMO, or any 3rd party payer. I understand I am responsible to Dr. Bravo for charges not covered by this assignment for any charges the carrier declines to pay. I authorize the release of my children's medical records as deemed necessary.

The Undersigned consents to treatment of the patient under the doctor's medical advice:

Mother/Guardian: _____ Father/Guardian: _____

Date: _____ Date: _____