



Baldwin Pediatrics
Rubina Azam, MD ,FAAP
625 W Baldwin Road
850-522-1522

PATIENT REGISTRATION

Patient Information:

Patient Name (Last): _____ First: _____ DOB: _____ Sex: M/F
Address: _____
City, State & Zip _____
Home Phone: _____
Social Security #: _____

Responsible Party Information:

Name: _____ Relationship to Patient: _____
Home Phone: _____ Work Phone: _____
DOB: _____ Address: _____
City, State & Zip: _____
Employer: _____
Occupation: _____
Social Security #: _____

EMERGENCY CONTACT: PHONE #: _____

Primary Insurance Company:

Policy Holder Name: _____
Policy Holder Date of Birth: _____
Relationship to Patient: _____
Employer: _____
Policy Number: Group Number: _____
Co-pay: Deductible: _____
Effective Date of Coverage: _____

Secondary Insurance Company:

Policy Holder Name : _____
Policy Holder Date of Birth: _____
Relationship to Patient: _____
Employer: _____
Policy Number: _____
Group Number: _____
Co-pay: Deductible: _____
Effective Date of Coverage: _____

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Baldwin Pediatrics. I authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature:

Date: