



BAYSHORE WOMENS HEALTHCARE
BOARD CERTIFIED IN OBSTETRICS & GYNECOLOGY

Patient Name: _____ DOB: ___/___/___ Age: _____

(Nombre) (Fecha de nacimiento) (Edad)

Social Security# _____ - _____ - _____ Marital Status: S M D

(seguro social)

Cell: ___ - ___ - _____ Home: ___ - ___ - _____ Work: ___ - ___ - _____ ext: _____

(cellular) (casa) (trabajo)

Address (direccion): _____

City: _____ State: _____ Zip Code: _____

(ciudad) (estado) (codigo postal)

Patient Occupation: _____

Employer (empleador) _____

Employer Address (direccion de empleador) _____

Spouse Name (nombre de esposo): _____

Spouse DOB (fecha de nacimiento): ___/___/___

Spouse Employer and address (empleador y direccion): _____

Phone (telefono) ___ - ___ - _____ ext: _____

Insurance Information / Informacion de Seguro

Primary Insurance Company: _____

(compania de seguro primario)

Address (direccion): _____

Phone (telefono): ___ - ___ - _____

Group# _____ Subscriber/Member# _____

Subscriber: _____ Relation to patient (relacion) _____

Secondary Insurance: _____

Address (direccion): _____

Phone (telefono): ___ - ___ - _____

Group# _____ Subscriber/Member# _____

Subscriber: _____ Relation to patient (relacion) _____

Release of information and assignment of benefits

I directly assign all medical/surgical benefits to _____ and understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Sign: _____ Date: _____

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