Robert Flores, MD Inc

Name:	Gender:	Marital Status:
Date of Birth:	SSN:	Phone:
Current Address:		City:
State and Zip code:	Language:	Do you require interpreter?
Race:	Ethnicity: Mexico Guatemala El Salvador Or Other:	
Mother's Maiden Name:	Email:	

Current Employer:	Occupation:	Phone:

Emergency Contact

Name:		Relationship:
Phone:	Address:	
City	State:	Zip code:

I authorize my medical information to be shared with the following individuals:

Insurance Information

Name of Insured:	Name of Primary Insurance:		
Date of birth:	SSN:	Phone:	
Address:	City:	State:	Zip code:
Relation to patient:			
Name of Secondary Insurance:	Name of Insured:		
Relation to Patient:	Date of Birth:	SSN:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am Financially responsible for any balance. I understand that if my plan is out-of-network or services are determinded "non-covered" due to plan provisions and/ Or pre-existing conditions of riders on my policy. I am fully responsible for all services incurred. I understand that if I elect to pay privately at my first visit, due To lack of insurance or failure to verify coverage, Robert Flores, MD Inc. may or may not retroactively submit claim or change account responsibility. I Understand that Robert Flores, MD Inc. will bill my insurance company according to all Federal rules and regulations regarding such activities and provides My insurance company with copies of all appropriate and require information and that Robert Flores MD Inc. is not responsible for lost claims. I also authorize Robert Flores, MD Inc. or insurance company to release any information required to process my claim.

Signature of Patient:	Date: