JISUE K. COYE, M.D., F.A.A.P.
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Torrance, CA 90503
(310) 370-7759 * Fax (310) 370-1590

Patient Registration

Full Name of Each Child	Nickname	Age	Birthdate
1.			
2.			
3.			
4.			

Insurance Information

Primary Insurance Plan Name _____ ID# _____ Group# _____

Name of Responsible Party (by guarantor) _____ Birthdate _____

Secondary Insurance Plan Name _____ ID# _____ Group # _____

Subscriber's Name _____ Birthdate _____

Parent Information

Children live with: ☐ both parents ☐ mother ☐ father ☐ other _____

Parent's Name _____	Parent's Name _____
Address _____	Address _____
Cell # _____ Home # _____	Cell # _____ Home # _____
Email _____	Email _____
Birthdate # _____ S. S. # _____	Birthdate # _____ S.S. # _____
Driver's License # _____ State _____	Driver's License # _____ State _____
Employer _____	Employer _____
Work Address _____	Work Address _____
Work Phone # _____	Work Phone # _____

Emergency Contact (other than parent)

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Privacy Constraints

How many we contact you with personal medical information?

☐ No Restrictions. It is ok to leave messages with information at the following number (s):

_____

☐ Restricted. Only non-specific messages

☐ Please note any other privacy restrictions _____

Authorization: I hereby authorize Dr. Jisue Coye to furnish information to insurance carriers concerning medical care, and I hereby irrevocably assign to the doctor all payments for medical services rendered.
I understand that I am responsible for providing accurate and current insurance and contact information at the time of service. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature: _____ Date: _____

Printed Name: _____ Relationship to patient: _____