ANGEL KIDS PEDIATRICS

JACKSONVILLE BREASTFEEDING CENTER

13241 Bartram Park Blvd, Suite 217
Jacksonville, FL 32258
13770 Beach Blvd, Unit 6
Jacksonville, FL 32224

Ashraf Affan, MD
Medical Director
Heather Logan, CLC
Certified Lactation Counselor
Jessica Buckler, CLC
Certified Lactation Counselor
904-242-4220 PHONE
904-674-2313 FAX

PATIENT REGISTRATION

❶ Mother's Name: **D.O.B.:**

Address: **Apt. #:**

City/state/zip:

Home Phone: **Cell Phone:**

❷ Infant's Name: **D.O.B.:**

❸ Emergency Contact: **Relationship:** **Phone:**

MOTHER'S INSURANCE/BILLING INFORMATION: (You must provide your current insurance card.)

❹ Insurance: □ **Private** □ **Medicaid** □ **Other or Self Pay**

Name of Primary Insured: **Policy#**

Name/Address of Employer:

City/state/zip:

Does your insurance REQUIRE a referral to see a specialist/consultant? □ **Yes** □ **No** □ **Not Sure**

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS:

I authorize Angel Kids Pediatrics (AKP) to treat myself and/or my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to AKP for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse AKP for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits.** I also understand that I am responsible for advising AKP of any and all changes to my insurance. Payment of co-pays are due on date of service.

❻ Signature: **Date:**