PEDIATRIC & TEEN CLINIC

Torrance Clinic:
1727 Crenshaw Blvd.
Torrance, CA 90501
(310) 373-7855

Carson Clinic:
1000 E. Dominguez St, Suite 110
Carson, CA 90746
(310) 715-7755

Fax: (424) 704-2493
www.EvangelineRoxasButligMD.com

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ Middle: ____________

Date of Birth: ______________________ Sex: ☐ Male ☐ Female

Social Security #: _______ / ______ / ________

Parent/Guardian Name: ______________________ Relationship to Patient**:** ______________________

Home Address: ____

City: ______________________ State: __________ Zip Code: ______________________

Home Phone: ______________________ Email Address: ______________________

Cell Phone: ______________________ Authorized to send messages via email: ☐ Yes ☐ No

Preferred Contact for Appointment Reminder: ☐ Home Phone ☐ Cell Phone ☐ Email

Work Address: ____

City: ______________________ State: ________ Zip Code: ______________________

Work Phone: ______________________

EMERGENCY CONTACT

Name: ______________________ Relationship to Patient: ______________________

Home Phone: ______________________ Cell Phone: ______________________

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I hereby authorize my insurance to make payments directly to Evangeline G. Roxas-Butlig, MD, Inc. for all surgical and medical expense benefits otherwise payable to me for treatment. I understand that I am financially responsible for all charges not covered by my insurance benefits. I am also responsible for return-check fees (minimum of $25 per check), interest (1.5% per month) and late fees of $25/month after 90-days of past-due invoices. I also authorize release of my records to the insurance company for purposes of billing, and to other physicians for purses of referrals. I also authorize and direct Evangeline G. Roxas-Butlig M. Butlig, MD, Inc. to order diagnostic, preventive, and therapeutic services which are deemed necessary for my healthcare.

Signature: Patient / Parent / Guardian / Insured

Date

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