Teena Hughes, M.D. P.A.
4444 E Fletcher Ave. Ste c
Tampa, FL 33613

REGISTRATION FORM Today's Date ______________

PLEASE PRINT

Patient's Full Name____ Age________

Date of Birth _________________ Male____ or Female____

Home Address____
Street City State Zip

Home Telephone_________________ Cell #____________________________

Emergency Contact____
Name Phone #

Mother's Name_____________________ Mother's Employer____________________

Mother's Date of Birth ________ Social Security #___________ Work Phone ________

Mother's Home Address ____

Father's Name_______________________ Father's Employer____________________

Father's Date of Birth_________ Social Security #___________ Work Phone_________

Father's Home Address ____

Have you or anyone in your family been a patient of this Doctor? YES NO

Who?_________________________ Relationship ____________________________

Whom may we thank for referring you to our office? ____________________________

I, the undersigned, confirm that I have read the privacy HIPPA policy posted in waiting room.

__________________________________ ____________________
Signature Date

Please allow us to photocopy your insurance card(s)

INSURANCE INFORMATION:

Payment for services rendered is to be made as follows:
"I request that payment of authorized insurance benefits be made to TEENA HUGHES, M.D., P.A., for any services or items furnished to me by the physician or supplier. I authorize the practice to release to the Health Care Financing Administration (HCFA/CMMS), my Insurance Carrier, and/or its agents appropriate information needed to determine these benefits or the benefit payable for related services, in accordance with HIPAA guidelines. Release of other information requires specific release authorization. I am financially responsible for appropriate deductibles, copayments, and non-covered items. If this account has to be turned over to an attorney due to delinquency or non-payment, I will be responsible for all costs of collection including the court cost and reasonable attorney fees."

____ ____________________
Signature of Responsible Party Date Signed

Consent for Treatment of Minor

I __________________________________, _______________________________ of
(your name) (relationship to patient)

____, give the doctors and other
(patient's name)
Health care workers of Teena Hughes, M.D., P.A. permission to examine, diagnose,

counsel, and treat _______________________________________ if another
(patient's name)
AUTHORIZED adult accompanies the patient to the visit until further notice.

____

____

____
(list name of authorized adults)

Note to the guardian of adolescent patients: Each visit is confidential and the doctors and other healthcare workers of Teena Hughes, M.D., P.A. are not privileged to discuss these visits with you unless the patient consents to disclose the information to you.

__________________________________ _______________________
Guardian's Signature Date