



**Ivette Valle, M.D.**

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### Welcome to our practice!

Thank you for selecting our team! We will strive to provide the best possible care. To help us meet your needs, please fill out this form completely. If you have any questions or need assistance, please do not hesitate to ask. We will be happy to help.

#### Patient Information

Name: \_\_\_\_\_ I Prefer to be called: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
The best time to contact me is: \_\_\_\_\_ on my  Home phone  Work phone  Cell phone  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Check Appropriate Box:  Minor  Single  Married  Widowed  Separated  Divorced  
If Student,  
Name of School \_\_\_\_\_ City \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_  
Email Address \_\_\_\_\_

#### Responsible Party Information

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ SSN# \_\_\_\_\_

#### Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN# \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

#### Insurance Authorization

I certify that I am covered by \_\_\_\_\_ insurance company and I assign directly to Ivette Valle M.D., P.A. all insurance benefits, otherwise payable to me, for services rendered. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance coverage does not cover. I hereby release the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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