ASK PEDIATRICS
1215 Lee Ave.
Tallahassee, Florida 32303
Tel: (850) 878-00229 Fax: (850) 942-5837
Aisha D. Bailey, D.O.

Patient's First Name: Age: Sex: DOB:

Patient's Last Name: Home Phone Number: Mobile Phone Number:

Home Street Address: City/State: Zip Code:

Primary Contact/Guardian Information

First Name: Relation to Patient: S.S.#:

Last Name: DOB: Primary Language:

Home Street Address: City/State: Zip code:

Home Phone Number: Mobile Phone Number: Work Phone Number:

Email Address: Preferred Contact Method (please circle):
Home Mobile Work Email

Secondary Contact/Guardian Information

First Name: Relation to Patient: S.S.#:

Last Name: D.O.B: Primary Language:

Home Street Address: City/State: Zip code:

Home Phone Number: Mobile Phone Number: Work Phone Number:

Email Address: Preferred Contact Method (please circle):
Home Mobile Work Email

Emergency Contact (other than parents)

Full Name: Relation to Patient: Contact Number:

Please list any additional people authorized to accompany the patient to appointments and consent to medical care

Full Name: Relation to Patient: Contact Number:

Full Name: Relation to Patient: Contact Number:

Authorization to pay benefits: I hereby authorize payment directly to Aisha D. Bailey, D.O. for any procedures including surgical, medical, physicals, and immunizations. I understand that if I am not eligible under the terms of my health plan agreement, or if for any reason the insurance company does not pay, that I am liable for all services rendered. I also understand that I am liable for fees incurred for missed appointments.

Primary Insured: X _____

Authorization for Medical Care: X _____

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