Patient Information 2018

FATHER:

Name: (last) _____
(first) _____
Date of Birth: _____
Street Address: _____Apt:__
City: _____
State: _____ Zip: _____
Marital Status: _____
_
Home Phone: ( ) _____
_
Work Phone: ( ) _____
_
Cell Phone: ( ) _____
_
Social Security # _____
Employer: _____
Address: _____
City: _____ State:___ Zip____
Occupation: _____
Number of Dependents: _____
Insurance Company: _____
Address: _____
City: _____ State:___ Zip____
Insured's I.D. # _____
Group Name or # _____
_

MOTHER:

Name: (last) _____
(Maiden Name):_____
(first) _____
Date of Birth: _____
Street Address: _____Apt: __
City: _____
State: _____ Zip: _____
Marital Status: _____
_
Home Phone: ( ) _____
_
Work Phone: ( ) _____
_
Cell Phone: ( ) _____
_
Social Security # _____
Employer: _____
Address: _____
City: _____ State:___ Zip____
Occupation: _____
Number of Dependents: _____
Insurance Company: _____
Address: _____
City: _____ State:___ Zip____
Insured's I.D. # _____
Group Name or # _____

CHILD (PATIENT): **RACE/ETHNICITY (OPTIONAL):** _____
_

Name: (last) _____ (first) _____ (M.I.) ___
Date of Birth: _____ Social Security # _____ Sex (M/F) ___
_
Street Address: _____ City _____ State _____
_
Zip: _____ Insurance: _____ID # _____
_
Emergency Contact: _____ Relationship: _____
Phone # _____ Cell phone # _____
_
Referred by: _____

The patient is responsible for all fees unless covered by an insurance plan in which we participate. We also require payment for our services when rendered unless other arrangements have been made with our billing department.

I hereby authorize Clarkstown Pediatrics to furnish information to insurance carriers concerning illness and treatments and I hereby assign to the physicians all payments for medical services rendered to my child/ children. I understand that I am responsible for any amount not covered by insurance. **I understand that I must call the office if I am unable to keep an appointment. This call needs to be made at least 24 hours prior to the appointment time. Otherwise Clarkstown Pediatrics will charge me a $25 fee.**

Date: _ _ _ _ _ _ _ _ _ _ _ _ Signature: _

PARENT'S EMAIL ADDRESS:_____