Patient Registration

Child Life Pediatrics, PC
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Carle Place, New York 11514
(516) 338 – KIDS (5437)

Building Healthy Lives Together...

Patient Information

Date: _____ How did you hear about us? _____

Patient Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Relationship to Guarantor: _____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Home Telephone: (___) _____

Next of Kin (not living at address listed above): _____ Relationship: _____

Address: _____

Siblings who visit this office:	**Name**	**Sex** (M/F)	**DOB** (mm/dd/yy)	**Social Security #**

Parent Information

Marital Status of Parents: ☐ **Married** ☐ **Divorced or Divorce Pending** ☐ **Single (never married)**

Mother's Name: _____ Date of Birth: _____ SS #: _____

Contact E-Mail Address: _____ *(You will receive periodic email newsletters)*

Home Address (if different from child): _____

City: _____ State: _____ Zip Code: _____ Home Phone: (___) _____

Employer: _____ Work Phone: (___) _____ Cell Phone: (___) _____

Father's Name: _____ Date of Birth: _____ SS #: _____

Contact E-Mail Address: _____ *(You will receive periodic email newsletters)*

Home Address (if different from child): _____

City: _____ State: _____ Zip Code: _____ Home Phone: (___) _____

Employer: _____ Work Phone: (___) _____ Cell Phone: (___) _____

Insurance Information

Primary Insurance Name: _____ Effective Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Full Name of Insured: _____ Date of Birth: _____ SS#: _____

Employer: _____ Policy Type: ☐ HMO ☐ PPO ☐ PPC ☐ Other: _____

ID Number: _____ Group Number: _____ Co-Pay Amount: _____

If you belong to an HMO, do you also have other Group Insurance Coverage? ☐ Yes ☐ No

Preferred Pharmacy Name: _____ Location/Phone: _____

Previous Physician: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: (___) _____

Name: _____ Relationship: _____ Phone: (___) _____

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Child Life Pediatrics, PC to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Child Life Pediatrics, PC

A photocopy of this authorization shall be considered as effective and valid as the original.

Parent Guardian Signature **Date** **Witness Signature** **Date**

***** Return this form to a staff member before leaving the office. Thank you. *****