

MDs4kids

--a division of Allied Pediatrics of New York, PLLC

Patient Name: _____ Date of Birth _____

IF EITHER PARENT HAS A LAST NAME DIFFERENT THAN ABOVE, PLEASE INDICATE:

Siblings: _____ Date of Birth _____
_____ Date of Birth _____

Address: _____

City: _____ State: _____ Zip: _____ Tel. : () _____

Your pharmacy's name and phone # _____

Mother/Guardian: _____ Date of Birth: _____ SS# _____

Father/Guardian: _____ Date of Birth: _____ SS# _____

Father's Employer _____ Business Tele: _____

Mother's Employer _____ Business Tele: _____

Primary Insurance Co: _____ Address: _____

Policy #: _____ ID# _____ Group # _____

Copay OV: _____ Copay Lab: _____

Policy Holder: _____ Policy Holder SS# _____

Secondary Insurance: _____ Policy Holder SS# _____

In emergency, contact: _____ Phone # _____

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the physician.

X _____ **Date** _____

I acknowledge receipt of the practice's "Notice of Privacy Practices."

X _____ **Date** _____

I am financially responsible for all services performed by the physician. I am responsible for all services deemed not covered or denied by my insurance company. **Any copayment due at time of visit and not paid at that time is subject to a \$10.00 service charge. Any balance sent for collection will be charged the NY state maximum allowable interest rate.**

X _____ **Date** _____