Pediatric & Adolescent Medicine, LLP

PATIENT INFORMATION

PLEASE PRINT CLEARLY.

Patient Name: ________________________________ Date of Birth: ___________

☐ Male ☐ Female ☐ Transgender

Patient Name: ________________________________ Date of Birth:____________

☐ Male ☐ Female ☐ Transgender

Patient Name: ________________________________ Date of Birth: ___________

☐ Male ☐ Female ☐ Transgender

Parent's names:____

Address: _______________________________________ Apt #: ________________

City, State, Zip code:____

Home phone:_________________________Cell phone: _____________________

Work phone: ____________________________________ext:__________________

E-mail address: ____

Emergency Contact Name: ____

Relationship to patients:____________Phone______________________________

Who referred you to our practice: ☐ Obstetrician ☐ Previous Pediatrician
☐ Existing Patient ☐ Other

Please indicate referral person's name: ___________________________________

390 West End Avenue #1E / New York NY 10024 / 212-787-1444 / FAX 212-799-8620
495 Central Park Avenue #305 / Scarsdale NY 10583 / 914-725-7555 / FAX 914-725-4553
www.pedsny.com

INSURANCE INFORMATION:

Primary Insurance: ____

Subscriber name:___________________________ Date of birth:__________

Subscriber ID:_________________________ Group ID: _________________

PREFERRED PHARMACY: (Multiple pharmacies can be added such as one local and one mail order)

Pharmacy name: ___________________________________

Address or pharmacy #:_______________________________

Phone number:_____________________________________

PREFERRED WAY TO CONFIRM APPOINTMENTS: ☐ EMAIL ☐ TEXT ☐ VOICE

☐ I grant Pediatric & Adolescent Medicine, LLP permission to view my child's medication history prescribed by other medical providers.

Parent Signature:__________________________________Date: _________

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