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 name: _____ Parent name: _____

Date of birth: _____ Date of birth: _____

Occupation: _____ Occupation: _____

Cell #: _____ Cell #: _____

Home phone: _____

Address: _____ Apt #: _____

City, State, Zip code: _____

Primary E-mail address: _____

Secondary E-mail address: _____

Emergency Contact Name: _____

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

Relationship to patients: _____Phone_____

Who referred you to our Practice:

☐Obstetrician ☐Previous Pediatrician ☐Existing Patient ☐Other/internet

Please indicate referral person's name: _____

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: _____