Patient's Name (above) | Date of Birth

Address | Telephone #

Allergies to Medications

Father's Name | Mother's Name **(& Maiden Name)**

Father's Employer/Work Phone # | Mother's Employer/Work Phone #

Father's Occupation | Mother's Occupation

Father's SS# and DOB | **Mother's SS# & DOB**

INSURANCE INFORMATION:

Insurance Name | Identification #

Insured Name (the person who carries the policy) | Effective date

ASSIGNMENTS OF INSURANCE BENEFITS:

I hereby authorize direct payment of surgical/medical benefits to SUFFOLK PEDIATRIC ASSOCIATES for services rendered by doctor(s) in person or under doctor(s) supervision. I understand I am financially resposible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize SUFFOLK PEDIATRIC ASSOCIATES, to release any medical or incidental information that may be necessary for either medical care or in processing applicants for financial benefit.

MEDICAID:

I certify that the information given by me in applying for payment is correct. I authorize relaease of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignements shall be valid as the original.

Parent/Guardian Signature | Date

Parent/Guardian (please print name)

NEWBORN INFORMATION

Newborns-MUST be added to the policy immediately after birth. The Policy must be a FAMILY plan. After 30 days there is a risk of losing coverage for the baby if he/she has not been added to the policy. Primary Care Physician (PCP) - you need to name a PCP when you enroll the Newborn, change Doctors or change Insurance. This applies to insurance companies which require PCP's.

I acknowledge that I have been informed of the insurance requirements for enrollment.

Signature | Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received SUFFOLK PEDIATRIC ASSOCIATES notice of Privacy Practices.

Signature | Print

Limitations | Date