# Parent or Guardian Information

***Parent #1***

Last Name:_____First Name:_____
Relationship: Mother/Father/Other (Relationship to child) _____

Phone (____)_____□Cell □Home □Work

Address (if different from child) _____

Parents SS# and DOB:_____Parents Employer and Work Number _____

Parents Occupation: _____

***Parent #2***

Last Name:_____First Name:_____
Relationship: Mother/Father/Other (Relationship to child) _____

Phone (____)_____□Cell □Home □Work

Address (if different from child) _____

Parents SS# and DOB:_____Parents Employer and Work Number _____

Parents Occupation: _____

Whom may we thank for referring you to our office? _____

# Insurance Information

Insurance Name: _____ Identification # _____

Insured Name: _____ 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 responsible 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 the processing applicants' financial benefit.

**MEDICAID**:
I certify that the insurance information given by me in applying for payment is correct. I authorize the release of all records on request. I request the payment of authorized benefits be made on my behalf. *A photocopy of these assignments shall be valid as the original.*

_____
Parent/Guardian Name Parent/Guardian Signature Date

Insured Name: _____Effective Date _____

**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.***

_____
Parent/Guardian Signature Date

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**
I have received **SUFFOLK PEDIATRIC ASSOCIATES** notice of *Privacy Practices*.

_____
Parent/Guardian Signature Print Name

_____
Limitations Date