

COMMUNITY PEDIATRICS, P.C.
657 East 233rd Street
BRONX, NY 10466
Phone: (718) 882-6388 Fax: (718) 882-6396

PATIENT INFORMATION SHEET

CHILD'S DATA:

Child's Last name: _____ First Name: _____ MI: _____

Child's Date of Birth: mm/dd/yyyy _____ Sex: M ___ F ___

Address: _____ Apt. #: _____

City: _____ State: _____ ZipCode: _____

Cell Phone #: _____ Home #: _____

Job Phone #: _____ Ext. _____ Other Phone #: _____

PARENTS'S DATA:

Parent's Last name: _____ First Name: _____

Date of Birth: mm/dd/yyyy _____ SS#: _____

Marital Status: __ Single __ Married __ Divorced __ Other Employment status: _____

Employer's/ School's: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Employer's Phone #: _____ Ext: _____

INSURANCE DATA:

Insured Last name: _____ First Name: _____ MI: _____

Insured Date of Birth: mm/dd/yyyy _____ Insured occupation: _____

Primary Insurance Company: _____

Insurance ID #: _____ Group Policy/Plan: _____ Group Name: _____

Secondary Insurance Company: _____

Insurance ID #: _____ Group Policy/Plan: _____ Group Name: _____

I certify that all the information above are accurate and authorize the release of all information to evaluate/process any claim submitted to my Insurance Company for payment to the Doctors at Community Pediatrics, PC.

I understand that I am responsible for any fees, deductibles and co-payments not covered by my insurance carrier. I will also co-operate in providing all necessary information so that all claims can be expedited and paid.

Signature (Insured or Authorized person)

Date