Beachside Pediatrics, LLC

Robin Straus Furlong, M.D.

Sandy Lieberman, M.D.

1145 Kane Concourse

Bay Harbor Islands, FL 33154

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PATIENT INFORMATION AND EMERGENCY MEDICAL CARE AUTHORIZATION

Patient's Name _______________________________________ Date of Birth______________________

Address______________________________City_____________State_____Phone_________________

Parent #1 Name______________________ Date of Birth______________ Phone_________________

Parent #2 Name ______________________ Date of Birth______________ Phone_________________

Other Children coming to our office ____

Parent #1 Email __________________________ Parent #2 Email ______________________________

Parent #1 Employer________________________ City___________ Phone _______________________

Parent #2 Employer________________________ City ___________ Phone _______________________

Insurance Name________________________ Member #__________________ Group# _____________

Subscriber's Name_______________________ Address____

Person Responsible for Payment_____________________________ Phone________________________

Address______________________________City_____________________________State_____________

Emergency Contact__________________________ Relation _____________ Phone _________________

OB/GYN (if applicable) ___________________________________Phone ___________________________

Referred By ______________________________ Languages spoken at Home______________________

Pharmacy _________________ Address______________________________Phone __________________

EMERGENCY CARE AUTHORIZATION

I authorize Robin Straus Furlong, M.D. or Sandy Lieberman, M.D. to provide any needed emergency care for my child named above in the event that I cannot be contacted at the time of need for such care.

Signed_________________________________Relation to Patient______________________ Date___________