PATIENT INFORMATION SHEET

Patient Name______________________ Date of Birth____________ Sex______

Address______________________ City ____________ State______ Zip Code_________

Patient Cell # ______________________ Religion____________ Race __________ Ethnicity________
*ONLY IF 16 OR OLDER

Pharmacy Name ______________________ **Phone #**______________________

Mother's Name______________________ Date of Birth______________________

Address______________________ City ____________ State______ Zip Code_________

Employer______________________ Job Title______________________ Work Phone #______________

Cell # ______________________ **Email**______________________ **Home #** ______________________

Father's Name______________________ Date of Birth______________________

Address______________________ City ____________ State______ Zip Code_________

Employer______________________ Job Title______________________ Work Phone #______________

Cell # ______________________ **Email**______________________ **Home #** ______________________

Primary Insurance Name______________________ Subscriber's Name______________________

Member ID #______________________ Group # ______________________

Claim Address______________________ City ______________________ Zip Code__________

Secondary Insurance Name______________________ Subscriber's Name______________________

Member ID #______________________ Group # ______________________

Claim Address______________________ City ______________________ Zip Code__________

Please Read and Sign Below

I will be financially responsible for any medical services not covered by my health insurance company. I authorize the payment of medical benefits to Westchester Pediatrics LLC. I authorize the release of any information needed to provide documentation for the amount billed.

SIGNATURE____ **DATE**________________