Bayside Pediatrics PC

www.BaysidePeds.com

BaysidePedsoffice@gmail.com

42-23 212th street Unit 1A Bayside
NY 11361 Tel:
(718)229-7337

PATIENT INFORMATION

Name:_____**Sex**:_____ **Age**:_____ **DOB**:_____

Address: _____

City: _____ **State**: _____ **Zip**:_____

Home Phone: (_____)_____ **Cell Phone**: (_____)_____

Business Phone: (_____)_____

FAMILY INFORMATION

Mother's Maiden Name: _____ **Mother's DOB:** _____
Father's Name: _____ **Father's DOB:** _____

IN CASE OF EMERGENCY

Name: _____ **Relation to Patient:** _____
Address:_____ **Phone: (_____)**_____

INSURANCE INFORMATION Primary Insurance

Insurance Company Name: _____ **ID#:** _____
Policy Holder's Name: _____ **Group#:** _____

Secondary Insurance **Insurance Company Name:** _____ **ID#:**
_____ **Policy Holder's Name:** _____

Group#: _____

AUTHORIZATION AND BENEFIT ASSIGNMENT

I hereby authorize the release of any information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor or group indicated on the claim.
I understand that I am financially responsible for any service or balance not covered by my insurance carrier and that it is my responsibility to follow all criteria under my insurance plan.

A copy of this signature is as valid as the original.

X_____ **Date:** _____