WANTAGH PEDIATRICS PLLC

Today's Date _____

Child's Name: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Home Address: _____

Home Phone # _____

> The primary carrier of insurance is the parent who carries family coverage and whose birth date comes first in the calendar year.

> If child/children are covered under Child Health Plus insurance, please put child/children's ID# next to the patient's name.

PRIMARY INSURED

NAME: _____

DOB: _____ SS # _____

HOME ADDRESS _____

HOME PHONE # _____ CELL PHONE # _____

EMPLOYER/BUSINESS ADDRESS _____

OCCUPATION: _____ WORK PHONE # _____

(CONTINUED ON BACK PAGE PLEASE TURN OVER)

OTHER PARENT/GUARDIAN INFORMATION

NAME: _____

DOB: _____ SS # _____

HOME ADDRESS _____

HOME PHONE # _____ CELL PHONE # _____

EMPLOYER/BUSINESS ADDRESS: _____

OCCUPATION: _____ WORK PHONE # _____

PLEASE READ AND SIGN

Authorization & Release: I authorize to release any information including the diagnosis and records of any treatment or examination provided my child to my insurance company and/or other healthcare providers.

Signature of Parent or Guardian _____ Date: _____

OTHER PARENT/GUARDIAN INFORMATION

NAME: _____

DOB: _____ SS # _____

HOME ADDRESS _____

HOME PHONE # _____ CELL PHONE # _____

EMPLOYER/BUSINESS ADDRESS: _____

OCCUPATION: _____ WORK PHONE # _____

PLEASE READ AND SIGN

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