COMMACK PEDIATRIC PARTNERS
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PLEASE FILL OUT ALL SPACES. DO NOT LEAVE ANYTHING BLANK. THE INFORMATION IS NECESSARY IN ORDER TO BE ABLE TO BILL YOUR INSURANCE COMPANY AND TO REACH YOU WITH INFORMATION REGARDING YOUR CHILD. IF WE ARE NOT ABLE TO BILL YOUR INSURANCE COMPANY BECAUSE OF DEFICIENT INFORMATION YOU WILL BE RESPONSIBLE FOR THE BILL.

Today's Date:_____
Patient First Name:_____Last name:_____ Gender: MALE/ FEMALE
Patient DOB: _____
Patient Address:_____City:_____Zip:_____
Patient Phone Number: (Home)_____(Mother/Partner Cell)_____
(Father/Partner Cell)_____
Who referred you to our practice?_____
If your entire family lives **at one address** and all the children in the household **are insured under the same plan** you may add additional children here.
Child #2_____DOB_____ ID#_____ MALE/ FEMALE
Child #3_____ DOB_____ ID#_____ MALE/ FEMALE
Child #4_____ DOB_____ ID#_____ MALE/ FEMALE
Child #5_____ DOB_____ ID#_____ MALE/ FEMALE

Insurance Information ***DO NOT LEAVE ANY BLANKS***
Insurance Company: _____
ID Number:_____
Group Number:_____
Insured's Name (This is NOT the child's name unless it is a Medicaid plan)_____
Insured's relationship to Patient:_____
Insured's DOB_____
Does your insurance require a PCP be named? Which physician is named?_____

Mother's First Name_____ Last name_____ DOB_____ *SS #_____
Address (if different from Patient)_____
Cell Phone_____ Circle one-Married/Divorced/Separated/Deceased
Employer_____ Employer's Phone Number_____

Father's First Name_____Last name_____ DOB_____*SS #_____
Address (if different from Patient)_____
Cell Phone_____Circle one-Married/Divorced/Separated/Deceased
Employer_____ Employer's Phone Number_____
*If you do not provide us with your social security number, you will be required to provide us with a copy of your NYS driver's license.

*I understand that I am responsible for knowing my insurance benefits and restrictions. I am responsible to know which hospitals my child(ren) can go to according to my insurance plan. I understand that it may not be a hospital that the physicians are affiliated with. I also understand that if I must designate a PCP (Primary Care Physician), either Dr. Danzi or Dr. Hajduk will be selected as the effective PCP at the **time of each visit** and that I will be financially responsible for all charges if I fail to comply. I hereby assign all benefits that are payable under my health coverage to Commack Pediatric Partners and authorize Commack Pediatric Partners to release personally identifiable and health related information to insurers, service providers and other healthcare providers. I understand that I am financially responsible to Commack Pediatric Partners for all costs associated with care provided by Commack Pediatric Partners to the above named patient .*

Authorized Signature: _____ Date: _____
Parent/Guardian