Bayside Pediatrics PC

www.BaysidePeds.com
BaysidePedsoffice@gmail.com
42-23 212th street Unit 1B
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: _____