



COMPREHENSIVE PEDIATRICS, PC

WWW.COMPREHENSIVEPEDIATRICSNY.COM

TODAY'S DATE _____

NEW PATIENT

UPDATED INFORMATION

ACCT# _____

VFC: YES NO

HOW DID YOU HEAR ABOUT US?

A1. PHYSICIAN: NAME: _____
ADDRESS: _____
TEL: _____

A2. HOSPITAL NAME: _____

A3. INSURANCE COMPANY A4. FRIEND/RELATIVE A5. YELLOW PAGES

A6. NEWSPAPER A7. VALPAK A8. INTERNET

A9. OTHER _____ Your E-Mail: _____

Please Print

PATIENT INFORMATION

Patient's Name _____

As It Appears on Insurance Card _____ Last _____ First _____ Mi _____

Male Female Date of Birth _____ Age _____

MM DD YYYY TODAY

HEALTH INSURANCE INFORMATION

MUST BE COMPLETED FOR COMPREHENSIVE PEDIATRICS TO BILL YOUR INSURANCE COMPANY

PRIMARY INSURANCE CARRIER

Insurance _____

Carrier Name _____

Policy _____

Holder Name _____

ID # _____

Group Number _____

Date Insurance Began _____

HMO PPO EPO Other

Copay _____ Annual Deductible _____

SECONDARY INSURANCE CARRIER

Insurance _____

Carrier Name _____

Policy _____

Holder Name _____

ID # _____

Group Number _____

Date Insurance Began _____

HMO PPO EPO Other

Copay _____ Annual Deductible _____

PLEASE REMEMBER TO HAVE YOUR INSURANCE CARD AT EVERY VISIT

PARENT'S INFORMATION

Mother's Name _____
Last First Mi

Social Security Number _____

Birthdate _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Phone Numbers: Home _____
Work _____
Cell _____

Employer's Name _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Father's Name _____
Last First Mi

Social Security Number _____

Birthdate _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Phone Numbers: Home _____
Work _____
Cell _____

Employer's Name _____

Address _____ Apt# _____

City _____ State _____ Zip _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I, _____, acknowledge that I am responsible and liable for all charges assessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Comprehensive Pediatrics. I understand that I am responsible for meeting my insurance deductibles and coinsurance and any noncovered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize the release to my insurance company of any medical information necessary to process a claim, and hereby assign payment of all medical benefits to Comprehensive Pediatrics.

Signature _____ Date _____