PREFERRED PEDIATRICS OF ROCKLAND
18 YEARS AND OLDER FORMS

PATIENT INFORMATION:

Name:_____

Date of Birth:_____/_____/_____ Age:_____ Gender:_____

Address:_____

City:_____ State: _____ Zip Code: _____

Patient's Email:_____

Patient's Cell Phone: (_____)_____-_____ Home Phone: (_____)_____-_____

PARENTS/ LEGAL GUARDIANAS INFORMATION: (MOTHER & FATHER)

Mother's Name:_____ Maiden Name:_____

Date of Birth: ____/____/_____Cell Phone: (_____)_____-_____ Home Phone: (_____)_____-_____

Father's Name: _____

Date of Birth: ____/____/_____Cell Phone: (_____)_____-_____ Home Phone: (_____)_____-_____

Primary Address (If different from yours) :_____

City:_____ State: _____ Zip Code: _____

EMERGENCY CONTACT: (OTHER THAN PARENTS)

Name:_____

Cell Phone: (_____)_____-_____ Home Phone: (_____)_____-_____

Relationship to Patient: GRANDPARENT AUNT/UNCLE FRIEND OTHER:_____

(CIRCLE ONE)

INSURANCE INFORMATION:

Insurance card(s) must be presented at the time of service. I GIVE PERMISSION FOR MY INSURANCE COMPANY(S) TO SEND PAYMENT DIRECT TO PREDERRED PEDIATRCS OF ROCKLAND. I AM AWARE THAT I MAY BE HELD RESPONSIBLE FOR ANY CHARGES NOT COVERED.

Parent's Signature:_____ **Today Date:** _____/_____/_____

Primary Insurance:_____	Secondary Insurance:_____
ID:_____	ID: _____
Subscriber's Name:_____	Subscriber's Name: _____
Subscriber's DOB : ____/____/_____	Subscriber's DOB : ____/____/_____

Print Name:_____ Preferred Pharmacy: _____

Signature: _____ Pharmacy Location:_____

Today's Date:____/_____/_____

PREFERRED PEDIATRICS OF ROCKLAND
PARENT'S FORMS

I GIVE PERMISSION FOR PREFERRED PEDIATRICS OF ROCKLAND TO SPEAK TO THE FOLLOWING INDIVIDUALS REGARDING LABORATORY/RADIOLOGY RESULTS AND PERSONAL HEALTH INFORMATION FOR

_____.

(PATIENT'S NAME)

NAME AND RELATIONSHIP/ PHONE NUMBER:

1. _____ (_____) _____-_____

2. _____ (_____) _____-_____

3. _____ (_____) _____-_____

4. _____ (_____) _____-_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____ (PARENT'S OR LEGAL GUARDIAN NAME) ACKNOWLEDGE RECEIPT (FURNISHED UPON REQUEST) A COPY OF THE PRIVACY PRACTICE OFPREFERRED PEDIATRICS OF ROCKLAND FOR

_____.

(PATIENT'S NAME)

PARENT OR LEGAL GUARDIAN:

PRINT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

TODAY'S DATE: _____/_____/_____

STAFF SIGNATURE: _____