Dr.G's Pediatrics
213-33 39th Ave Suite 340 Bayside, New york 11361
Phone: 347-207-5507 Fax:646-233-3781

PATIENTS' INFORMATION (MANDATORY) ***Please read the HIPPA form***

Patients' Complete Legal Name:	**Circle one:** Male Female
Patients' DOB: _____/_____/_____ Month / Day / Year	**Patients' Social Security #:**
Patients' Siblings: #1 Name: _____ DOB: _____/_____/_____ #2 Name: _____ DOB: _____/_____/_____	
Home Address: **No Post Office** _____ _____	
Telephone #s: (Can be a cell number) **Must have a minimum of one contact number**	
Mother's #: (_____) _____-_____	**Mother's Work #:** (_____) _____-_____
Father's #: (_____) _____-_____	**Father's Work #:** (_____) _____-_____

INSURANCE INFORMATION

The following information is needed for identification and insurance purposes. Everything must be completed. Caretakers are responsible for accuracy and for up to date information. If the patient does not have insurance, we need parents' full name and date of births. If parent is not listed, we will not release information to that parent.

Guarantor # _____ **What Insurance is effective as of today?** _____

Who is the primary insured? _____ **Father or Mother?**

Father's Full Legal Name	**Father's DOB** _____/_____/_____ Month / Day / Year
Father's Social Security #	**Father's Email**
Name of Insurance Carrier:	
Mother's Full Legal Name	**Mother's DOB** _____/_____/_____ Month / Day / Year
Mother's Name as listed on the birth certificate:	
Mother's Social Security #	**Mother's Email**
Name of Insurance Carrier:	

If there is a recent change of address, telephone numbers, insurance, or primary insured, please circle: Yes or No

PLEASE READ BEFORE SIGNING: To my knowledge, all the information provided by me on this form is both accurate and up to date. I know that I am solely responsible for any fraudulent or misleading information.

_____ **Print Full Name**

_____ **Relationship to Patient (Mother/ Father/ Other)**

_____ **Legal Signature**

_____/_____/_____ **Today's Date**