Gomathi Pediatrics PLLC
67 North Main Street, 2nd Floor, New City, New York 10956
Tel: 845-634-8911, Fax: 845-634-9002

PATIENT INFORMATION FORM

(Please fill out completely and legibly – Thank you.)

Date ______________________

How were you referred to our practice? Friend________ Dr.________ Hospital___________ PhBk ____ Ins_____ Other________________

Patient Name (Last, First, MI) ____ ___________Sex (circle) Female Male
(As it appears on the insurance card)

Address ____ Apt#____________ City _________________ State______ Zip____________

Home Phone: _________________________ Work Phone: _________________________ Ext________ Cell Phone: _________________________

Date of Birth______/______/________ Social Security # ___________-_____________-___________ Driver's License# _____________________

Employer/School Name ____ Occupation __________________________________

Address ____ City _________________ State______ Zip ____________

Full time college student? Y / N If Yes - Is dependent verification on file with insurance? Y / N Office Staff Verification___________

Person Responsible for Payment________________________________ SS#_____-_______-________ Relationship to patient _________________

Address ____ Apt#____________ City _________________ State______ Zip____________

Home Phone: _________________________ Work Phone: _________________________ Ext________ Cell Phone: _________________________

Other family members who live in the same household as patient:

Name	Date of Birth	Relationship to Patient	Seen Here? Yes/No
	MM/DD/YYYY		
	MM/DD/YYYY		
	MM/DD/YYYY		
	MM/DD/YYYY		
	MM/DD/YYYY		
	MM/DD/YYYY		

Coordination of Benefits: New York State Regulations: "…when both father and mother of an eligible dependent child have separate health insurance policies, the policy of the parent having a birth date earlier in the year is primary."

INSURANCE INFORMATION (Please hand all insurance cards to front desk so we can make a copy)

Primary Insurance

Company ____ **Policy#**_________________________ **Group#**________________

Insurance Co. Address____ **City** _________________ **State**______ **Zip**____________

Insurance Co. Phone____________________________________ **Copay Amount** ________________ **Deductible Amount** ______________

Policy Holder Name (Last, First, MI)____ **Relationship to patient**________________________

Policy Holder Address____ _______________ **City** _________________ **State**______ **Zip**____________

Home Phone: ________________________ **Work Phone:** ________________________ **Ext**________ **Cell Phone:** ________________________

Policy Holder Date of Birth______/______/______ **Social Security #** ___________-_____________-___________ **Driver's License#** ______________________

Policy Holder Employer____ **Tel#** ____________________________________

Employer Address____ _______________ **City** _________________ **State**______ **Zip**____________

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Secondary Insurance Information

Company ________________________ **Policy#**________________________ **Group#**________________

Insurance Co. Address________________________ **City** ________________ **State**______ **Zip**____________

Insurance Co. Phone________________________ **Copay Amount** ________________ **Deductible Amount** ______________

Policy Holder Name (Last, First, MI)________________________ **Relationship to patient**________________________

Policy Holder Address________________________ ______________ **City** ________________ **State**______ **Zip**____________

Home Phone: ________________________ **Work Phone:** ________________________ **Ext**________ **Cell Phone:** ________________________

Policy Holder Date of Birth______/______/______ **Social Security #** ___________-_____________-___________ **Driver's License#** ______________________

Policy Holder Employer________________________ **Tel#** ________________________

Employer Address________________________ ______________ **City** ________________ **State**______ **Zip**____________

EMERGENCY INFORMATION

Name of person to Contact in an Emergency________________________ **Relationship to patient**________________________

Address________________________ **Apt#**____________ **City** ________________ **State**______ **Zip**____________

Home Phone: ________________________ **Work Phone:** ________________________ **Ext**________ **Cell Phone:** ________________________

Office Financial Policy

If patient is 18 years or older they are their own guarantor and will be held financially responsible for all visits regardless of insurance status of parents. Failure to follow dictates of insurance plan regarding full time dependent student verification for students, enrollment of newborns within the prescribed 30 days of birth, or failure to file co-ordination of benefits may result in denial of payments, or denial of routine, non-emergency care, a hold on your account, or dismissal from the practice unless the matter is resolved timely and payment arrangements are made with the business office. If insurance denies payments for any reason, the patient/guarantor will be held responsible for payment and any unpaid balances will be subject to third party and or attorney collection efforts and patients will be responsible for any fees and finance charges that may accrue.

The person who brings the dependent child in to the office for care is responsible for paying any applicable copayments or deductibles on account. We require a written authorization if the parent or legal guardian is unable to accompany the child to the office. We do not bill for copayments and any copayments not paid at time of service will be subject to a late fee of $20. Any check that is returned unpaid by the bank is subject to a $25 fee. Dishonored Checks will be sent to third party collections and may have an effect on your credit rating. We accept cash, money orders, check and credit cards.

Appointment confirmations will be left on the home telephone number and/or a cell phone of the patient/guardian unless otherwise notified. Please notify us 48 hours in advance for appointments that need to be cancelled or rescheduled. Failure to notify us will result in a $25 cancellation fee. Periodically we will ask for confirmation and acknowledgement of the information on this registration form. Please inform us promptly of any changes of the information on this form. Insurance cards are required to be shown at time of service. Please make sure you bring your cards and copayment for every visit.

AUTHORIZATION

Consent for treatment: I authorize Gomathi Pediatrics PLLC to provide me/my child with reasonable and proper medical care according to today's standards.
Financial Responsibility, Authorization to Release Information, Assignment of Benefits: I authorize Gomathi Pediatrics PLLC to release information in connection with my treatment to my insurance company or companies, my employer or any third party payer at such time as information is requested. I authorize assignment of benefits to Gomathi Pediatrics PLLC.
I understand and agree that I am financially responsible for any and all charges incurred. I have read and understood the office financial policy.

Patient/Guardian Signature________________________ **Date**________________________