



An Affiliate of



## Patient Information /Demographics

Today's Date:\_\_\_\_\_

Please list dependents, First Name, Last Name, Date of Birth below:

Patient PCP: ☐ Dr. Munteanu ☐ Dr. Fallon  
☐ Dr. Schwartz

Patient's Primary Language: \_\_\_\_\_

Patient's Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to disclose

Patient's Race: ☐ American Indian/ AK Native ☐ Asian ☐ Black or African American  
☐ Native HI/Pacific Island ☐ White ☐ Prefer not to disclose

### Parent / Guardian Demographics

Parent 1 First Name:\_\_\_\_\_ Last Name:\_\_\_\_\_ DOB:\_\_\_\_\_

Parent 1 Cell:\_\_\_\_\_ Parent1 Work Phone:\_\_\_\_\_

Parent 2 First Name:\_\_\_\_\_ Last Name:\_\_\_\_\_ DOB:\_\_\_\_\_

Parent 2 Cell:\_\_\_\_\_ Parent2 Work Phone:\_\_\_\_\_

Guardian's First Name:\_\_\_\_\_ Last Name:\_\_\_\_\_ DOB:\_\_\_\_\_

Address:\_\_\_\_\_

City:\_\_\_\_\_ State:\_\_\_\_\_ Zip:\_\_\_\_\_

Email Address:\_\_\_\_\_

Home Telephone:\_\_\_\_\_

Preferred number for evening reminder calls: ☐ Home ☐ Parent 1 cell ☐ Parent 2 cell

**Preferred Pharmacy:**\_\_\_\_\_

**City:**\_\_\_\_\_

**We require you to have access to the online patient portal for access to forms, online bill paying and secure communication with our office.**

Preferred email or mobile number for portal \_\_\_\_\_

## GUARANTOR / INSURANCE INFORMATION

Insurance Carrier Name: \_\_\_\_\_

Policy / ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Person who has insurance: First \_\_\_\_\_ Last \_\_\_\_\_

Address (If different than previously listed) \_\_\_\_\_

Phone \_\_\_\_\_ email \_\_\_\_\_

If individual insurance ID numbers are provided by insurance carrier please list below:

Patient Name \_\_\_\_\_ ID # \_\_\_\_\_

Patient Name \_\_\_\_\_ ID # \_\_\_\_\_

Patient Name \_\_\_\_\_ ID # \_\_\_\_\_

## EMERGENCY CONTACT : (in the event the parent(s) cannot be reached)

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## CONSENT

### Consent to release:

I hereby authorize the physicians of this practice to release any and all medical information to the above name insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until it is revoked in writing. I have read this authorization and understand it.

### Consent to assignment:

I hereby assign payment of medical services to this practice to which I am entitled or have incurred for medical and/or surgical expense relative to services rendered here. I understand I am financially responsible to said group for charges not covered by this assignment. I further agree in the event of non-payment to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

### Consent to treat:

I authorize this practice to provide medical care to my child and authorize treatment of care in my absence if my child is accompanied by the following care giver (check all that apply:)

☐ Grandparent(s) / Sibling(s) Name(s): \_\_\_\_\_

☐ Nanny / Babysitter Name(s): \_\_\_\_\_

☐ Other \_\_\_\_\_ Name(s): \_\_\_\_\_

**PLEASE NOTE:** Unless accompanied by a note from a guardian, vaccinations will not be administered to minors.

**Signature of Parent / Legal Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

☐ I confirm the accuracy of all information on page 1 of this document

☐ I confirm the accuracy of all information on page 2 of this document