



PATIENT INFORMATION FORM (18+)

TODAY'S Date: _____

PATIENT #: _____

815 HALLOCK AVE., SUITE A
 PORT JEFFERSON STATION, NY 11776
 631-331-7267

6144 RT. 25A, BLDG C, SUITE 19
 WADING RIVER, NY 11792
 631-929-0325

PATIENT DEMOGRAPHIC WORKSHEET

P A T I E N T	PATIENT NAME		DATE OF BIRTH	SEX	AGE	ALERT NOTE <u>Y</u> <u>N</u> AUTHORIZATION RESTRICTION <u>Y</u> <u>N</u>	
	PATIENT STREET ADDRESS		CITY AND STATE	ZIP	Patient Resides With: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Siblings <input type="checkbox"/> Others		
	PATIENT TYPE 18+		CHART Location		PRIMARY CONTACT (CIRCLE ONE) HOME CELL EMAIL		
	HOME PHONE		CELL PHONE ()		EMAIL ADDRESS		

INSURANCE INFORMATION

I N S U R A N C E	(CIRCLE ONE) NONE (VFC) MEDICAID (VFC) HEALTHY NY (VFC) THE EMPIRE PLAN PPO HMO EPO POS COPAY \$ _____					
	PRIMARY INSURANCE		EFFECTIVE DATE	ID / GROUP NUMBER		
	POLICY HOLDER NAME		RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
	SECONDARY INSURANCE		EFFECTIVE DATE	ID / GROUP NUMBER		
POLICY HOLDER NAME		PATIENT / POLICY HOLDER RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER		

FINANCIAL

DOES THIS PATIENT'S INSURANCE REQUIRE AN AUTHORIZATION OR REFERRAL NUMBER? (CIRCLE ONE) YES NO

IT IS MY RESPONSIBILITY TO PROVIDE KIDS FIRST PEDIATRICS WITH ACCURATE INSURANCE INFORMATION REGARDING MY COVERAGE AND TO INFORM THEM OF ANY CHANGES WITHIN THIRTY DAYS (30) OF THE CHANGE.
 I HEREBY AUTHORIZE ASSIGNMENT AND PAYMENT DIRECTLY TO KIDS FIRST PEDIATRICS, P.C., FOR MEDICAL SERVICES RENDERED. I AM AWARE, ALTHOUGH I MAY OR MAY NOT BE COVERED BY INS, I AM PERSONALLY RESPONSIBLE FOR THE PATIENT BALANCE ON MY ACCOUNT WHICH MAY INCLUDE DEDUCTIBLES, CO-PAYS, OR CO-INSURANCE FOR WHICH MY INSURANCE COMPANY DEEMS ME RESPONSIBLE. I AM AWARE KIDS FIRST PEDIATRICS, AS WELL AS MY INSURANCE CO, REQUIRE PAYMENT DUE AT THE TIME OF SERVICE. IF NOT PAID AT THE TIME OF SERVICE I WILL BE CHARGED AN ADDITIONAL \$5 STATEMENT PROCESSING FEE.

SIGNED: _____ DATE: _____

AUTHORIZATION

I HEREBY AUTHORIZE KIDS FIRST PEDIATRICS, P.C. TO RELEASE INFORMATION TO MY INSURANCE COMPANY. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION, INCLUDING PRIVILEGED, SENSITIVE INFORMATION, TO MY SCHOOL IF REQUESTED, ANY HOSPITAL, PROVIDER IN THIS PRACTICE AND TO ANY SPECIALIST MY PROVIDER MAY REFER ME TO. I ALSO GIVE PERMISSION TO KIDS FIRST PEDIATRICS TO LEAVE ANY PERSONAL HEALTH INFORMATION RELATING TO ME ON MY ANSWERING MACHINE (HOME OR CELL) PERTAINING, BUT NOT LIMITED TO LABORATORY RESULTS, ACCOUNT INFO, OR QUESTIONS UNLESS RESTRICTED BELOW:

RESTRICTED: _____

I HEREBY AUTHORIZE KIDS FIRST PEDIATRICS TO RELEASE PERSONAL HEALTH INFORMATION RELATING TO MY MEDICAL CARE TO THE FOLLOWING PERSON(S)

_____ PHONE _____

SIGNED: _____ DATE: _____

C O N S E N T

PATIENT NAME	DATE OF BIRTH	SEX	AGE
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Consent For Participation in NYSIIS for Individuals 19 years of age or older

The New York State Immunization Information System (**NYSIIS**) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in **NYSIIS** include:

- Your health care provider can use **NYSIIS** to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in **NYSIIS** for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

I give my consent for Kids First Pediatrics, PC to release my immunizations(s) and identifying information to the New York State Immunization Information System (**NYSIIS**). I understand the purpose of **NYSIIS** is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.

The immunization information in **NYSIIS** may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in **NYSIIS**. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by **NYSIIS** with my consent will remain in **NYSIIS** if I later choose to withdraw my consent. However, future immunizations will not be recorded in **NYSIIS**.

Print Name

Date of Birth

Signature

Date