Date: _____Child's Dr. /N.P. _____ Referred By: _____

| **Patient/Children's First & Last Name(s)** | **DOB** | **Gender M/F** | **Lives with Mother/Father/Both** |
|---|---|---|---|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |

**PLEASE CIRCLE OR FILL IN THE REQUIRED STATE AND FEDERAL REGULATIONS Brighton Hill Pediatrics must be in compliance with**

**1. Ethnicity:** Hispanic Latino Neither **2. Language: _____**

**3. Race**: Native American Asian Black/African American Native Hawaiian White

**Mother's Maiden Name** _____New York State Law **REQUIRES** this information for the Immunization Registry.

**Primary Parent/Guardian:** Name _____DOB_____SEX: M F SS#_____

Address _____City_____State_____Zip _____

Home Phone # _____Cell Phone # _____ Work #_____

Employer _____Occupation _____

**I give BHP permission to call or leave messages on (circle all that apply): Home Cell Work**

**Parent/Guardian/Step:** Name_____ DOB _____SEX: M F SS#_____

Address _____City_____State_____Zip_____

Home Phone #_____Cell Phone # _____ Work #_____

Employer _____Occupation _____

**I give BHP permission to call or leave messages on (circle all that apply): Home Cell Work**

**E-MAIL Address**_____ Receive E-Mail Newsletter Y_____ N_____

**Pharmacy of Choice**_____

**BILLING INFORMATION (PLEASE COMPLETE THIS ENTIRE SECTION, INCLUDING POLICY ID'S)**

**RESPONSIBLE PARTY FOR BILLS (name/address):**_____

**Primary** Insurance Company _____**Policy/ID #**_____

Subscriber's First & Last Name _____DOB_____

**Secondary** Insurance Company _____**Policy/ID #** _____

Subscriber's First & Last Name _____DOB_____

**EMERGENCY CONTACTS** (other than a parent or guardian) **Name(s), Phone Number(s) and Relationship**_____

_____

Does your home have well water? _____ Year that your home was built? _____