NEW PATIENT INTAKE FORM

Date: _____

Patient Name:_____ DOB _____GENDER _____

Patient Name:_____ DOB _____GENDER _____

Patient Name:_____ DOB _____GENDER _____

Patient Name:_____ DOB _____GENDER _____

Patient Name:_____ DOB _____GENDER _____

Patient Name:_____ DOB _____GENDER _____

Parent Name:_____ Phone# _____

Address: _____ Referred by: _____

Name of Insurance:_____ Policy#: _____

Address of Insurance: _____

Subscriber Name / DOB: _____ / _____ Effective Date: _____

Please choose a provider: [ ] Derek Gorski, DO [ ] Elizabeth Cassalia, DO

Reason for transferring to BHP? _____

Any Medical Issues? _____

_____

Last Physical(s) _____

When are child(ren) due for next appt? _____

Please COMPLETE the above, and fax to 315 469-4482, or mail to Brighton Hill Pediatrics, 151 Intrepid Lane, Syracuse, New York 13205. Once reviewed and approved, you will be contacted as to next steps to becoming a patient.

Office Use Only

Insurance verified? Y / N Staff Initials _____ Insurance Code _____

PCP Reviewed/assigned? Y / N Assigned to: _____ Referred to: _____

Parent/Patient notified? Y / N Records Requested? Y / N Records received (date) _____

Appt Scheduled? Y / N