NEW PATIENT INFORMATION SHEET

When registering, please present proof of insurance. Co-pay is expected at the time for service, unless special arrangements are made. Payment may be made by cash, check, Visa, MasterCard, and Discover.

PATIENT INFORAMTION: DOB: _____ Sex: F or M

Last Name_____ First Name_____ Middle Initial _____

Address_____ City_____ State_____ Zip Code_____

Phone # _____

Please Circle or fill in the required information in compliance with State and Federal Regulations
1. Ethnicity: Hispanic Latino Neither **2. Language:** _____

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

Primary Pharmacy: _____

INSURANCE INFORMATION

RESPONSIBLE PARTY FOR BILLS (name/address):

_____

Primary Insurance
Name of Insurance _____ Policy#_____

Subscriber of Insurance _____ Subscriber DOB _____

Relation to Patient_____

Secondary Insurance
Name of Insurance_____ Policy#_____

Subscriber of Insurance _____ Subscriber DOB _____

Relation to Patient _____

DO YOU CURRENTLY HAVE NYS MEDICAID COVERAGE? Circle One: NO YES

If **YES**, Provide CIN# _____

PARENT INFORMATION

Primary Parent/Guardian Name_____ DOB _____Gender _____

Full Address (if different from above_____

Home Phone #_____Cell Phone# _____

Employer_____ Work #_____

Parent/Guardian Name_____ DOB _____Gender _____

Full Address (if different from above_____

Home Phone #_____Cell Phone# _____

Employer_____ Work #_____

EMERGENCY CONTACTS (other than parent/guardian) **Name(s), Phone #, Relationship:**

_____

AUTHORIZATION TO TREAT & RELEASE OF INFORMATION CONSENT FORM I/We being parent(s) or legal guardian(s) of the named minor above, do hereby appoint the listed person(s) written in section A below to have access to personal health information, either written or verbal, and hereby appointment to act in my behalf in authorizing medical, dental, surgical care and/or hospitalization in my/or absence. I/We understand that my child's records may contain information regarding the diagnosis or treatment of sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric disease. I understand that in accordance with Federal and State Laws, this release does NOT include permission to release information specifically related to HIV (AIDS) and if such information is to be requested, additional specific release forms.

A. Persons authorized to receive information/consent to treatment-(for Ex. Step-parents, girl/boyfriends, babysitters/nannies, GRANDPARENTS, medical caregivers) If a person other than the parent/legal guardian, is not listed below , they will be unable to gain access to personal health information, either written or verbal.

NAME OF PERSON	**RELATIONSHIP TO PATIENT**
_____	_____
_____	_____
_____	_____

This consent expires on the patient's 18th birthday. You may revoke or terminate this consent by submitting a written revocation at any time. You should contact the Privacy Officer to terminate consent. Information that is disclosed under this consent may be disclosed again by any person or organization to which it is sent. The privacy of that information may not be protected under federal privacy regulations.

_____ _____

Parent/Guardian **Date**