NEW PATIENT INTAKE FORM

Date: ______________________________

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** **[ ] Lauren Carlyle, MD**

Reason for transferring to BHP? ____

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