

Please print this form, fill it out and bring it to your first visit, with the insurance card, a photo ID and the vaccine record. You can also fill one out in the office. Please print clearly.

1. Patient

First name Middle Last name Date of birth (MM/DD/YYYY)

Sex: ☐ Male ☐ Female ☐ Other / prefer to describe: _____

Preferred language: ☐ English ☐ Spanish ☐ Russian ☐ Other: _____

Home address (street) Apt City State ZIP

2. Parents or legal guardians

If the patient is 18 or older, write the patient's own phone and email in Parent/guardian 1 and mark "Self".

Parent/guardian 1

Full name Mobile phone Other phone

Relationship to patient: ☐ Mother ☐ Father ☐ Legal guardian ☐ Self ☐ Other: _____

Email

Parent/guardian 2

Full name Mobile phone Other phone

Relationship to patient: ☐ Mother ☐ Father ☐ Legal guardian ☐ Self ☐ Other: _____

Email

3. Insurance

☐ No insurance / self-pay

Primary insurance

Insurance company / plan Member ID Group number

Subscriber (policy holder) name Subscriber date of birth Subscriber's relationship to patient

Secondary insurance (if any)

Insurance company / plan Member ID Group number

Subscriber (policy holder) name Subscriber date of birth Subscriber's relationship to patient

4. Emergency contact (someone other than the parents above)

Name Relationship to patient Phone

First name / Last name (Patient)

Date of birth (MM/DD/YYYY)

5. Pharmacy

Pharmacy name

Address or cross streets

Phone

6. Health history

Previous pediatrician or doctor

Their phone☐ No known allergies

Allergies (medicines, foods, other) and the reaction

Medicines the patient takes now (name and dose)

Medical conditions (for example asthma, eczema, diabetes)

Surgeries or hospital stays (what and when)

For babies: hospital where born, birth weight, any problems at birth**Vaccine record:** ☐ I will bring it ☐ Previous doctor will send it ☐ I don't have it

7. How may we contact you?

Check yes or no for each. You can change your choice at any time by calling the office.

Phone calls☐ Yes☐ No

Appointment reminders and calls from the office

Phone number for calls**Text messages**☐ Yes☐ No

Appointment reminders and office messages

Mobile number for texts☐ OK to leave a voicemail with appointment details

By checking Yes for text messages, I agree to receive text messages from Jackson Heights Pediatrics with appointment reminders and office messages at the mobile number above. Message frequency varies. Msg & data rates may apply. Reply STOP to opt out or HELP for help. Agreeing is not required to receive care.

8. Signature

The information on this form is correct to the best of my knowledge.

Signature of parent/guardian (or patient, if 18 or older)

Date

Printed name

Relationship to patient**For office use only**

Chart #: _____

Entered by: _____

Insurance verified: _____