RECORD RELEASE AUTHORIZATION

To: ____

PREVIOUS FACILITY/ PRACTICE

____

ADDRESS

____

PHONE NUMBER & FAX NUMBER

1582 RICHMOND AVE STATEN ISLAND NY 10314 (718)761-0623 FAX (718) 761-0769

I authorize and request all medical records and details in their possession. I understand that the information in my medical record may include information related to treatment of drug abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

PATIENT NAME ____

PATIENT DATE OF BIRTH ____

PATIENT ADDRESS ____

PHONE NUMBER ____

SIGNATURE ____

RELATIONSHIP TO PATIENT ____

NEW PATIENT INFORMATION (PLEASE PRINT) DATE:________________

NAME SEX: M F______________

S.S # BIRTHDATE__________________

ADDRESS____________________________________ PHONE_____________________

CITY STATE ZIP

LANGUAGE: RACE: ETHNICITY:

PARENT/GUARDIAN INFORMATION

FATHERS NAME CELL#

S.S.# BIRTHDAY

ADDRESS PHONE ______

CITY STATE ZIP

EMPLOYER WORK PHONE

ADDRESS

MOTHERS NAME CELL#

S.S.# BIRTHDAY

ADDRESS PHONE ___________

CITY STATE ZIP

EMPLOYER WORK PHONE

ADDRESS

PRIMARY EMAIL____

PREFERRED CONTACT METHOD: ☐ MAIL ☐ EMAIL ☐ PHONE

NAME OF PREFERRED PHARMACY AND LOCATION:

INSURANCE INFORMATION

PRIMARY POLICY INSURANCE COMPANY ______________________________

ADDRESS ____________________ CITY ____________ STATE ______ ZIP ______

NAME OF INSURED ______________________________ RELATIONSHIP __________

POLICY # ______________________________ GROUP # __________

SECONDARY POLICY INSURANCE COMPANY ______________________________

ADDRESS ____________________ CITY ____________ STATE ______ ZIP ______

NAME OF INSURED ______________________________ RELATIONSHIP __________

POLICY # ______________________________ GROUP # __________

INSURANCE IS FILED BY THIS OFFICE AS A COURTESY TO THE PATIENT. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS THE PARENTS RESPONSIBILITY TO BE AWARE OF BENEFITS THAT THEIR INSURANCE PROVIDES FOR WELL CHILD CARE AND SICK VISITS. ALL INSURANCE COPAYMENTS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Marina Pediatrics P.C. to furnish information to insurance carriers concerning my illness and/ or treatment and hereby assign to the physician all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

SIGNATURE ______________________________ DATE ______________

INITIAL HISTORY QUESTIONNAIRE

Date completed:
NAME:
DOB:

ALLERGIES: **Food**
Medication
Environmental

Birth History

Type of Delivery Vaginal € C-Sect €
Birth weight __________________________ Full Term _____ Pre-term_____
Feeding Formula ______________________ Breast feed Yes ______ NO ________

HOUSEHOLD

Are there any siblings? If so, please list their names, age, and where they live.
____
____

What is the child's living situation if not with both biological parents?

€ Lives with adoptive parents € Joint custody € Single custody

€ Lives with foster family

Family History

History **Yes** **No**

History	Yes	No
Asthma		
Tuberculosis		
Anemia		
Bleeding Disorder		

Bed- Wetting (after 10 years old)		
Obesity		
Other		

Past History

History	Yes	No
Frequent Ear Infections		
Asthma, bronchitis, pneumonia		
Heart Murmur or any heart condition		
Anemia		
Other		
Other		

Any Other concerns you would like the physician to know:

____
____
____
____