WNY Pediatric ENDOCRINOLOGY

New Patient Registration Form

PATIENT INFORMATION:

Patient Name: _____ **Sex:** M F

Birth date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone :_____

E-mail address: _____

Ethnicity: White Black/African American Asian Other: _____

Race: Spanish/Hispanic Non Hispanic

Primary Language: _____

Parent 1 Name: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Birth date: _____

Home Phone: _____ Mobile Phone: _____

Parent 2 Name: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Birth date: _____

Home Phone: _____ Mobile Phone: _____

Health Insurance: _____ Subscriber ID#: _____

Policy Holder Name: _____ DOB: _____

Secondary Health Insurance: _____ Subscriber ID#: _____

Primary Pharmacy: _____ Phone #: _____

I hereby authorize payment of medical benefits billed from my insurance to **WNY Pediatric Endocrinology, PLLC**. I hereby accept responsibility for payment for any services provided to me that are not covered by my insurance I also accept responsibility for fees that exceed the payment made by my insurance. If a referral in not provided at the time service is rendered, I will be responsible for the total amount due for services rendered. I agree to pay all copayments, coinsurance and deductibles.

Print Name: _____ Date: _____

Signature of Patient or Guardian: _____