PEDIATRICS OF NEW YORK
11 E. 86th Street, Suite 1B
New York, NY 10028

Telephone: 212-535-3131
Fax: 212-535-4159
www.pediatricsofny.com

Erika Landau, M.D. Anna Duszka , M.D Preeti Parikh, M.D. Yael Wapinski, M.D.

WELCOME TO OUR PRACTICE

Child's name: _____ Date of birth: _____ **Sex:** Female/Male: _____

Mother's/Parent 1's name: _____ Date of birth: _____

Home address: (street / apt#): _____

City, state, zip code: _____ SS#: _____

Home telephone: _____ Cell: _____ Work telephone: _____

Email: _____ Profession: _____ Work address: _____

Father's/Parent 2's name: _____ Date of birth: _____

Home address (street / apt#): _____

City, state, zip code: _____ SS#: _____

Home telephone: _____ Cell: _____ Work telephone: _____

Email: _____ Profession: _____ Work address: _____

Name of person caring for the child (other than the parents): _____

Address (if different from the parent): _____

Telephone numbers: 1: _____ 2: _____

Names of siblings: _____ Date of birth: _____
_____ Date of birth: _____
_____ Date of birth: _____

Correspondence address (if different from home / above)

_____
_____

Referred by: _____

PATIENT (Parent's) SIGNATURE: _____ **DATE** ____/_____/_____

BIRTH HISTORY (FOR CHILDREN 6 YEARS OLD AND YOUNGER)

Hospital: _____

Type of delivery: _____ Complications: _____

Birth weight: _____ Birth length: _____

Discharge weight: _____

Type of feeding: _____

Any problems at or after the birth:

_____

_____

FAMILY HISTORY

Do any parents or grandparents or other close relatives have the following medical conditions?

Tuberculosis	☐YES	☐NO	Diabetes	☐YES	☐NO
Anemia	☐YES	☐NO	Asthma	☐YES	☐NO
Convulsions	☐YES	☐NO	Heart Disease	☐YES	☐NO
Birth Defects	☐YES	☐NO	Kidney Disease	☐YES	☐NO
Cancer	☐YES	☐NO	Learning Problems	☐YES	☐NO
Vision, Speech, or Hearing Problems	☐YES	☐NO	Developmental delays	If yes: in men or women	

Other: _____

CHILD'S PAST MEDICAL HISTORY

Previous doctor: _____

Address: _____

Telephone: _____ Email: _____

Any past illnesses:

_____

_____

Any past surgeries: _____

Allergies: _____ Medication: _____

Behavior or developmental problems:

_____

_____

PARENT / GUARDIAN SIGNATURE: _____ **DATE:** _____/_____/_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, ***Pediatrics of New York***, may use and disclose protected health information (PHI) about my child to carry out treatment, payment and healthcare operations (TPO). Please refer to ***Pediatrics of New York's*** "Notice of Privacy Practices" for a more complete description of such uses and disclosures.

I have the right to review the "Notice of Privacy Practices" prior to signing this consent. ***Pediatrics of New York*** reserves the right to revise its "Notice of Privacy Practices" at anytime. A revised "Notice of Privacy Practices" may be obtained by forwarding a written request to ***Pediatrics of New York's*** Privacy Officer at the address above.

With my consent, ***Pediatrics of New York*** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to any clinical care, including laboratory results among others.

With my consent, ***Pediatrics of New York*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked as personal and confidential.

With my consent, ***Pediatrics of New York***, may email to me appointment reminder cards and patient statements. I have the right to request that ***Pediatrics of New York*** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

SIGNED BY: _____ _____

(Signature of Patient / Legal Guardian) (Relationship to Patient)

_____ _____

(Patient's Name) (Date)

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WELCOME TO OUR OFFICE

Insurance information:

Insurance name: _____ Insurance ID: _____
Name on the insurance: _____ Relationship to child: _____
Is your child added to your insurance? Yes/No

Do you have a secondary insurance?
Insurance name: _____ Insurance ID: _____
Name on the insurance: _____ Relationship to child: _____
Is your child added to your secondary insurance? Yes/No

Authorization to release information and assignment of benefits to physician:

I hereby authorize Pediatrics of New York to release information acquired in the course of my child's examination and treatment.
I hereby assign payment of the medical benefits for the services rendered directly by all physicians at Pediatrics of New York.
I understand that I am personally responsible for any charges not covered by the insurance as well as for the deductible amount.

Parent's (Guarantor's): Signature: _____ Printed name: _____
Date: __/___/____

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Consent to treat the child in the parent's absence

I give permission for my child to be medically evaluated and treated at Pediatrics of New York in my absence. I understand that it may be necessary to perform diagnostic tests (for example, a throat culture or blood test) in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.
This consent applies to:

1. Complete check-up (including blood and urine samples)
2. Hearing, vision, scoliosis, and blood pressure screening
3. Immunizations
4. First aid and emergency care
5. Prescription and treatment for illness
6. Referrals to an outside agency (for example: hospital, radiology) for services not provided in the office.

If there are any services that you do not consent to in your absence, please list:
_____
My child will be accompanied by:
[ ] Self (name) _____
[ ] Babysitter (name) _____
[ ] Other (name, relationship) _____

I give permission for the physician to share any relevant health information with the person who is accompanying my child.

_____ _____
Child's name, Date:

_____

Parent or Guardian Signature: _____
Parent or Guardian Name: _____
Phone number where parent or guardian can be reached: _____