SV Pediatrics, PC
155 East Woodside Avenue
Patchogue, NY 11772
Phone: 631-758-6565 Fax: 631-758-6568

Welcome to SV Pediatrics! Please help us by filling in the following information.
Thank you for your time.

Patient Name:	Birthdate:
Address:	Apt. #:
City:	State:
Zip:	
Phone Number (with area code):	email address:
Mother's Name or Legal Guardian:	Phone Number:
Address:	
Father's Name:	Phone Number:
Address:	
Siblings:	Ages:

INSURANCE INFORMATION:

Insurance Company:	Insured Person's Name:
Insurance ID Number:	Group Number:
Insured's Birthdate:	Insured's SSN:
Insured's Address:	City:
State:	Zip:
Insured's Phone Number:	
Insured's Employer:	Business Phone Number:
Insured's Employer Address:	City:
State:	Zip:

Referred By:

I understand that the information that I have provided is true to the best of my knowledge.
I understand that any wrong information may delay treatment or may cause denials from insurance companies.

Signature

Date

Relationship to Patient (in not patient)

SV Pediatrics, PC
155 East Woodside Avenue
Patchogue, NY 11772

Guarantee Agreement

For, and in consideration of , services rendered by SV Pediatrics, PC to the patient whose name appears below, the undersigned (jointly or severally, if more than one) hereby promise(s) to pay to SV Pediatrics, PC any co-payment, coinsurance or fees required by my coverage with any insurer/HMO/or other third party payor. In addition, I promise to pay for all services (together with all collection costs) which I am advised by SV Pediatrics, PC prior to receiving them that such services are not covered by my benefit plan with any such insurer/HMO/or third party payor. However, I/we understand hat I/we will have no responsibility to pay for any procedure/service/device which is included in another claim paid by any insurer/HMO/r third part payor of the same service date or which is include in the overall "bundled" payment of any procedure/service/device. I/We further understand that all bills are payable and become due upon presentation.

I/We hereby assign SV Pediatrics, OC all monies and/or benefits to which I/we may be entitled from my coverage with any insurer/HMO/third party payor, government agencies, or those who are financially liable for my medical care to cover the costs of the care and treatment rendered to me or my dependents...

I/We hereby authorize and direct SV Pediatrics, PC to release any insurer/HMO/third party payor, governmental agencies, or to whoever is financially liable for my medical care, all information needed to substantiate payment for such medical care, and if required for pre-certification/prior approval services.

I/We understand it is our responsibility to contact our insurance carrier and Name SV Pediatrics, PC as primary care physician of applicable to my/our coverage.

_____ _____

Signature of Authorized Person **Date**

_____ _____

Patient Name **Relationship to Patient**

_____

Witness

Notice of Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive with our practice. We need this record to provide you with quality care and to comply with legal requirements. We will not disclose any of your information for any purpose not listed, without your written authorization. Any specific written authorization you provide may be revoked at any time in writing to our office. We reserve the right to change our privacy practices and the terms of this notice at any time, provided that changes are permitted by law.

Authorization to Release Medical Information

Patient Name: _____

Date of Birth: _____

You may use or disclose the following medical/health information:

_____ All health information maintained by SV Pediatrics, PC

_____ Health information relating to the following treatment or condition

_____

You may disclose medical information to:
Name: _____ **Telephone #**_____

Address: _____

Reason For disclosure: _____
_____.

Signature of Patient/Guardian: _____
Date: _____

Welcome To SV Pediatrics

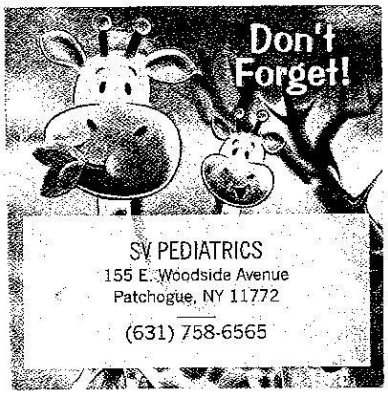
Please be advised of about the following information:

- If you have a newborn, it is the parent/ guardian's responsibility to contact the insurance company to inform them about your child's birth and have them enrolled on the policy prior to having an office visit.
- If you are a new patient or have a change of insurance it is the responsibility of the parent/guardian to name SV Pediatrics as the Primary Care Physician prior to being seen. Failure to do so will make you financially responsible for all services.
- If you choose to alter the vaccination schedule, for your child please be advised that you may be held responsible for the cost of vaccines as your insurance company may only cover a certain number of well visits per year.
- Please be advised that copayments are required at time of service. We reserve that right to apply a fee for all copayments not paid at the time of service.
- Please be advised that we reserve the right to apply a fee of $25.00 for any well physical examination if we do not receive 24 hour advance notification of cancellation. Confirmation phone calls are done as a courtesy.

- **I understand the provided information.**

_____ _____

Signature of Parent/Guardian **Date**



SV Pediatrics, PC

155 East Woodside Avenue
Patchogue, NY 11772

Medical Release Form

I, _____, authorize _____ to release all medical records regarding _____, including documents relating to diagnosis, treatment, consultations, growth, etc. to the office listed below:

SV Pediatrics, PC
155 East Woodside Avenue
Patchogue, NY 11772
Phone: 631-758-6565
Fax: 631-758-6568

_____
Signature of Authorized Person

_____
Relationship to Patient

_____
Patient's Social Security #

_____
Witness

_____
Date

SV PEDIATRICS NEW PATIENT VISIT

Today's Date: _____

PATIENT NAME: _____

Date of birth: _____ **Age:** _____ **years** _____ **months**

History given by: ☐ Mom ☐ Dad ☐ Grandparent ☐ Other _____

BIRTH HISTORY

☐ Full Term ☐ Premature, born at _____ weeks gestation

☐ Natural Delivery ☐ C-Section - reason _____

Any complications during Pregnancy, at Delivery, or in the Newborn Nursery? ☐ Yes ☐ No

If yes, please state _____

_____

PAST MEDICAL HISTORY

☐ No significant medical history.

If there is any significant medical history or illnesses, list them below. Provide dates if possible.

_____

_____

_____

PAST SURGICAL

☐ No past surgical history.

If there were any surgeries done, please list them below. Provide dates if possible.

_____

_____

_____

ALLERGIES

☐ No Known Allergies.

If there are any significant allergies, please list below.

_____

_____

_____

MEDICATIONS

☐ No medications taken at this time.

If your child is taking any medications, please list below.

_____

_____

_____

FAMILY MEDICAL HISTORY

☐ No significant family medical history.

If there are any medical issues known in your immediate family please list them below.

_____

_____

_____

_____ _____

PARENT SIGNATURE **PROVIDER SIGNATURE**

PT NAME: _____ **DOB:** _____ **DATE OF SERVICE:** _____