



--a division of Allied Pediatrics of New York, PLLC

**NEWBORN INTAKE**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Delivery Hospital: \_\_\_\_\_ Baby seen by Doctor: \_\_\_\_\_

**IF EITHER PARENT HAS A LAST NAME DIFFERENT THAN ABOVE, PLEASE INDICATE:**

\_\_\_\_\_

Siblings: \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Tel. : ( ) \_\_\_\_\_

Your Pharmacy's name and phone # \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Father's Employer \_\_\_\_\_ Business Tele: \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Business Tele: \_\_\_\_\_

Primary Insurance Co: \_\_\_\_\_ Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Copay OV: \_\_\_\_\_ Copay Lab: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder SS# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Holder SS# \_\_\_\_\_

In emergency, contact: \_\_\_\_\_ Phone # \_\_\_\_\_

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the physician.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_

I acknowledge receipt of the practice's "Notice of Privacy Practices."

**X** \_\_\_\_\_ **Date** \_\_\_\_\_

I am financially responsible for all services performed by the physician. I am responsible for all services deemed not covered or denied by my insurance company. **Any copayment due at time of visit and not paid at that time is subject to a \$10.00 service charge. Any balance sent for collection will be charged the NY state maximum allowable interest rate.**

**X** \_\_\_\_\_ **Date** \_\_\_\_\_