

Today's Date: _____ Patient's Chart # _____

ARE YOU ALREADY ESTABLISHED WITH SUMMIT PEDIATRICS? [] YES [] NO if yes, name of the child/children established _____

PARENT INFORMATION (list person responsible for insurance)

Primary ins: [] Father [] mother [] other
 Secondary Ins: [] Father [] mother [] other
 Third Ins: [] Father [] mother [] other

Statements will be mailed to the household where the child resides

Father: _____ Date of Birth _____ / _____ / _____ SS: _____
 Address _____ City _____ St _____ Zip _____
 Phone _____ Cell _____ other _____
 Employer _____ Address _____ Phone _____
 Additional information for emergency notification _____

Mother, first and Last name _____ Date of Birth _____ / _____ / _____ SS: _____
 Mother's Maiden Name _____ Necessary to Identify patient with NYS immunization Program
 Address if different from above _____ City _____ ST _____ Zip _____
 Phone _____ Cell _____ other _____
 Employer _____ Address _____ Phone _____
 Additional information for emergency notification _____

INSURANCE INFORMATION (Please allow receptionist to photocopy **all** your insurance ID Cards) If child has Medicaid, list in Patient information. list a Managed Care if applicable:

PRIMARY INS _____ ID# _____ Grp# _____ Copay \$ _____ Eff date: _____
 SECOND INS _____ ID# _____ Grp# _____ Copay \$ _____ Eff date: _____
 THIRD INS : _____ ID# _____ Grp# _____ Copay\$ _____ Eff.date: _____

Patient: _____ _M [] F [] Date of Birth _____ / _____ / _____ _SS: _____

Does this child have Medicaid? [] yes [] no , Medicaid ID # _____ does this child have primary ins listed above? [] yes [] no

If yes: What is the Suffix (last 2 digits of the ID number) _____

THIS CHILD LIVES WITH [] Both parents, [] father, [] mother, [] other, if other please identify: name ,address, phone and relationship:

Patient: _____ _M [] F [] Date of Birth _____ / _____ / _____ _SS: _____

Does this child have Medicaid? [] yes [] no , Medicaid ID # _____ does this child have primary ins listed above? [] yes [] no

If yes: What is the Suffix (last 2 digits of the ID number) _____

THIS CHILD LIVES WITH [] Both parents, [] father, [] mother, [] other, if other please identify: name ,address, phone and relationship:

Patient: _____ _M [] F [] Date of Birth _____ / _____ / _____ _SS: _____

Does this child have Medicaid? [] yes [] no , Medicaid ID # _____ does this child have primary ins listed above? [] yes [] no

If yes: What is the Suffix (last 2 digits of the ID number) _____

THIS CHILD LIVES WITH [] Both parents, [] father, [] mother, [] other, if other please identify: name ,address, phone and relationship:
