Pediatric Associates of New York City, PC

Registration Form

Patient/s Information (you may use 1 form for up to 2 kids)

Name: ______________________________ #2 ______________________________
DOB: child #1 ____________________ 2nd child ______________________
Address: ______________________________________ Apt. ______________
City: _________________________ State: _______________ Zip: _______________
Home# ___________________________ Alternate# ___________________________

Parent #1

Name: __________________________________ Gender: Male or Female
DOB: _________________________ S.S # __________________________________
Address: ______________________________________ Apt. ______________
City: _________________________ State: _______________ Zip: _______________
Home# ___________________________ Alternate# ___________________________

Parent #2

Name: __________________________________ Gender: Male or Female
DOB: _________________________ S.S # __________________________________
Address: ______________________________________ Apt. ______________
City: _________________________ State: _______________ Zip: _______________
Home# ___________________________ Alternate# ___________________________

Insurance Information (note if child is covered by more than 1 policy please provide information for both)

Primary Insurance: _____________________ /Ins. Id # _______________________
Policy Holder's relationship to child:
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Secondary Insurance: _____________________ /Ins. Id # _______________________
Policy Holder's relationship to child:
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