PEDIATRIC ASSOCIATES OF NYC, P.C.

317 East 34 Street New York, NY 10016 (212) 725-6300	20 Plaza Street East Brooklyn, NY 11238 (718) 857-5500	22-18 Jackson Avenue Long Island City, NY 11101 (718) 786-5506

New Patient Registration Form

Patient/s Information

Name: Child #1________________________________ Date of Birth ____________

Child #2_______________________________ Date of Birth_____________

Child #3________________________________ Date of Birth ____________

Address:____Apt.__________

City:__________________________State:________________Zip:___________

Home #____________________________

Email address ____

Parent #1 Name: ______________________________Gender: Male Female Other

DOB: __________________________

S.S #___________________________________

Address (if different than child):

____Apt.__________

City:_______________________State:____________Zip:____________

Email address ____

[]Home#__________________[]Cell #_________________[]Work#______________

Please check preferred number to call

Parent #2 Name: _______________________________Gender: Male Female Other

DOB: __________________________

S.S #___________________________

Address (if different than child): _____________________________________Apt.___________

City: _______________________State:______________Zip:________________

Email address ____

[]Home#_____________________[]Cell#______________________[]Work#______________

Please check preferred number to call

Insurance Information (Provide information for both carriers if child is covered by more than one policy)

Primary Insurance: ______________________/Ins. Id #________________________

Policy Holder's relationship to child: _______________________________________

Secondary Insurance: ______________________/Ins. Id #____________________

Policy Holder's relationship to child: ____