



# Eastchester Pediatric Medical Group

JOSE BOYER M.D. RAJESH BISNAUTH M.D. ROSEMARY CALLIGARIS M.D.  
266 White Plains Road, Eastchester, New York. 10709  
Phone: (914) 337-3960 Fax: (914) 395-1537  
www.EastchesterPeds.com - E-mail: info@EastchesterPeds.com

## PATIENT INFORMATION

### MOTHER

NAME (First Last) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SOC. SEC. NUM \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_

WORK PHONE ( ) \_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_

### FATHER

NAME (First Last) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SOC. SEC. NUM \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_

WORK PHONE ( ) \_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_

### INSURANCE

#### **MOTHER'S INSURANCE COMPANY**

POLICY # \_\_\_\_\_

ID# \_\_\_\_\_

GROUP#/NAME \_\_\_\_\_

TYPE OF COVERAGE \_\_\_\_\_

#### **FATHER'S INSURANCE COMPANY**

POLICY # \_\_\_\_\_

ID# \_\_\_\_\_

GROUP#/NAME \_\_\_\_\_

TYPE OF COVERAGE \_\_\_\_\_

### CHILDREN

**1.NAME** \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SOC. SEC. NUM \_\_\_\_\_

**3.NAME** \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SOC. SEC. NUM \_\_\_\_\_

**2.NAME** \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SOC. SEC. NUM \_\_\_\_\_

**4.NAME** \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SOC. SEC. NUM \_\_\_\_\_

#### **Co-pays are required at time of office visit.**

If you have immunization records please give them to us. If your child has any medical conditions or allergies we should be informed.

A signed permission note must be given to us if your child is not accompanied by a parent or guardian.

I understand that if my insurance is not in effect at time of visit, I will be responsible for all medical services at Eastchester Pediatric Medical Group.

I authorize Eastchester Pediatric Medical Group to give reasonable and proper care, by current standards, to my child.

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Date