Pediatric Healthcare of Long Island

This form is used to update the demographic information for your entire family.
It should be filled out ONCE a year per family.

Family Demographic Information:

Family Information:
Family Name: _____

Home Address: _____ City _____ State ____ Zip _____ Home Phone ( ) _____-_____

Parents' Information:

Mother/Father (circle one):	Mother/Father (circle one):
First Name: _____ Last Name: _____ Date of Birth: ___/___/_____ SSN:_____-____-_____ Address (if different from above): _____ City _____ State _____ Zip_____ Phone Numbers: Home (if diff from above): ( ) _____-_____ Work: ( ) _____-_____ Cell: ( ) _____-_____ Email Address: _____@_____.com	First Name: _____ Last Name: _____ Date of Birth: ___/___/_____ SSN:_____-____-_____ Address (if different from above): _____ City _____ State _____ Zip_____ Phone Numbers: Home (if diff from above): ( ) _____-_____ Work: ( ) _____-_____ Cell: ( ) _____-_____ Email Address: _____@_____.com

Preferred Communication (circle one): Home/Work/Cell: Which parent? _____
***WHO IS THE LEGAL GUARDIAN? _____ *WHO IS FINANCIALLY RESPONSIBLE? _____**

Children's Information: Please provide the following information for all of your children Office Use:

First Name	Last Name	Gender	Birth Date	Cell Number	Email Address	Flag:
		M/F	____/____/_____	( ) _____-_____	_____@_____.com	
		M/F	____/____/_____	( ) _____-_____	_____@_____.com	
		M/F	____/____/_____	( ) _____-_____	_____@_____.com	
		M/F	____/____/_____	( ) _____-_____	_____@_____.com	
		M/F	____/____/_____	( ) _____-_____	_____@_____.com	
		M/F	____/____/_____	( ) _____-_____	_____@_____.com	
		M/F	____/____/_____	( ) _____-_____	_____@_____.com	

Race (circle one): Caucasian/African American/Latino/American Indian/Asian/Other
Ethnicity (circle one): Hispanic or Latino/Non-Hispanic or Latino/Unknown
Preferred Language if other than English (circle one): Spanish/Russian/Hebrew/Other: _____

Preferred Pharmacy Information: Pharmacy Name: _____ Town _____ Street _____

How did you hear about our practice (circle one): Ad/Insurance/Internet/OB/Friend/Specialist Physician
Name of Friend or Physician who referred you: _____

Insurance Information: Please provide our Receptionist with your Insurance card.
Type of Insurance: _____ Policy Holder's Name: _____ Policy #: _____

YOU ARE RESPONSIBLE TO NAME PEDIATRIC HEALTHCARE OF LI OR ONE OF THE PHYSICIANS IN THE GROUP AS YOUR PRIMARY CARE PHYSICIAN (PCP). IF YOU DO NOT NAME PEDIATRIC HEALTHCARE OF LI OR ONE OF THE PHYSICIANS IN THE GROUP AS YOUR PRIMARY CARE PHYSICIAN (PCP), YOU WILL BE RESPONSIBLE FOR ALL FEES NOT COVERED BY YOUR INSURANCE CARRIER.

I have reviewed Pediatric Healthcare of LI's Notice of Privacy Policy. I have been informed that should I have questions regarding PHLI's Privacy Policy or do not understand information in the Policy, that I may direct these questions to Peter Singh.

Parent/Guardian Signature _____ **Date** _____

For Office Use Only: Initials of Individual Entering Information: _____