Northwell Health Physician Partners | Westchester Health

You may list multiple children on this form *ONLY IF* they all have the same address, parent/guardian, and insurance information. Otherwise *YOU MUST* complete a separate form for each child. If you have any questions please ask our staff prior to proceeding.

PATIENT INFORMATION

1. Last Name_____ First Name_____ Middle _____
   Date of Birth_____ Sex: _____
2. Last Name_____ First Name_____ Middle_____
   Date of Birth_____ Sex: _____
3. Last Name _____ First Name_____ Middle_____
   Date of Birth_____ Sex: _____
4. Last Name_____ First Name_____ Middle _____
   Date of Birth_____ Sex: _____
5. Last Name_____ First Name _____ Middle_____
   Date of Birth _____ Sex: _____
6. Last Name_____ First Name _____ Middle_____
   Date of Birth _____ Sex: _____

Address _____ City _____ State _____ Zip_____

Race _____ Language _____

Ethnicity (please select one) Hispanic_____ non-Hispanic_____ declined_____

Home Phone # _____Preferred Email_____

_____

Please indicate which number is your Preferred Method of Contact: ☐Home ☐Cell ☐Work ☐Patient Portal

Primary Care Physician _____

Preferred Pharmacy Name _____ Phone _____

In Case Of Emergency Who Should We Notify _____

Phone Number _____ Relationship _____

If patient is under 18, please indicate Mother's Maiden Name _____

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PARENT/GUARDIAN INFORMATION

Patient Last Name: _____

Parent: Full Name_____**Gender:**_____Date of Birth_____

Relationship: ☐Biological ☐Step ☐Foster ☐Legal Guardian ☐Other_____

Address_____City_____ State_____ Zip_____

Home Phone _____Cell Phone _____ Work Number_____

Employer _____

Parent: Full Name_____**Gender:**_____Date of Birth_____

Relationship: ☐Biological ☐Step ☐Foster ☐Legal Guardian ☐Other_____

Address_____City_____ State_____ Zip_____

Home Phone _____Cell Phone _____ Work Number_____

Employer _____

Other: Full Name_____**Gender:**_____Date of Birth_____

Relationship: ☐Biological ☐Step ☐Foster ☐Legal Guardian ☐Other_____

Address_____City_____ State_____ Zip_____

Home Phone _____Cell Phone _____ Work Number_____

Employer _____

FINANCIAL RESPONSIBILITY

Who is financially responsible (Guarantor) for this patient? _____ (Please be aware that whoever brings the child in for the appointment is responsible for the charges for that day)

INSURANCE INFORMATION - Primary Insurance

Plan Name _____ Policy # _____ Group # _____

Name of Insured (Policy Holder) _____

Relationship to Patient _____ Date of Birth _____

Address _____ City _____ State _____

Home Phone # _____ Work Phone # _____

Secondary Insurance (if Applicable)

Plan Name _____ Policy # _____ Group # _____

Name of Insured (Policy Holder) _____

Relationship to Patient _____ Date of Birth _____

Address _____ City _____ State _____

Home Phone # _____ Work Phone # _____

Patient Last Name: _____

Westchester Health will not contact you regarding your confidential medical information via email. We currently have a patient portal which will allow us to communicate with you securely. We do not sell or distribute email addresses. We will use email addresses to inform you about upcoming seminars or important health recommendations. Please indicate in the Preferred Email field if you do not wish to receive emails from Westchester Health.

Please identify if you have any barriers to communication, for example, need interpreter, having hearing or vision barriers (Please identify patient(s) name(s) with barrier)

_____

_____

I, the undersigned, hereby certify that I have Insurance coverage and assign all insurance benefits to Westchester Health, if any, for services rendered. I understand that I am responsible for all co-payments/co-insurance, deductibles and otherwise elective non-covered services provided to me (or my dependents). I authorize the use of this signature on all insurance submissions.

I, the undersigned, hereby agree that I am financially responsible for all services provided to me by Westchester Health.

Print Name_____

Signature _____ Date _____

Westchester Health is an equal opportunity employer and healthcare organization. We are committed to excellent health care for all of our patients. Questions related to patients' race and ethnicity are included to comply with federally mandated programs for utilizing an electronic health record. You may decline to answer these questions.