

Four Seasons Pediatrics, LLC * 532 Moe Road * Clifton Park, NY 12065

Today's Date: _____ Family Last Name: _____

Please list all children:

Name: _____ Middle Initial _____ DOB: _____ Sex: _____ Allergies: _____

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Name: _____ Middle Initial _____ DOB: _____ Sex: _____ Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Main Phone #: _____ Is this # cell or home ? _____

Patients Primary Care Physician (as listed with Insurance company): _____

Mother's Maiden Name (the child's/children's biological mother): _____ Mother's DOB _____

Is English your family's primary spoken language? _____ If no list primary language _____

Race or Ethnicity: _____

Please list any vision or hearing issues (related to communication) _____

Please list your primary pharmacy (Location and/or phone number) _____

Parent contact numbers: (or legal guardian)

Name: _____ Relationship: _____

Work phone: _____ Cell: _____

Name: _____ Relationship: _____

Work phone _____ cell _____

E-mail address _____

Emergency Contact (other than parent) _____ Relationship to patient _____

Home # _____ Cell # _____

Insurance Information: Enter policy holder / subscriber information. If the patient is the policy holder (e.g. Fidelis - CHP) please list responsible party (parent/legal guardian) information here:

Policy Holder (or responsible party):

Last name: _____ First name: _____ Middle initial _____

DOB: _____ / _____ / _____ Sex: _____ SS#: _____

Address: If address & phone is the same as patient just write 'same'

Street: _____ City: _____ State: _____ Zip: _____

Home phone: _____

Employer: _____ Occupation: _____

Work phone: _____

Name of insurance: _____ Effective date: _____

Patient's policy #: _____ Group number: _____

Does your insurance require a copay? _____ If so what is the copay amount: \$ _____

Is there a secondary insurance? If yes, please provide information about 2nd policyholder:

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Phone # _____

Email: _____

Employer: _____ Work Phone _____

Name of Insurance: _____ Policy Number: _____

Group Number: _____ Policy Effective Date: _____

Does your insurance require a copay? _____ If yes, what is your copay amount? _____

Please bring insurance Card(s) with you to all appointments, thank you.