Williamsville Pediatric Center

PATIENT INFORMATION

Please print.

Last name: First name:		DOB:	Race/Ethnicity:
Street address:		City	State
Zip code:	Home Phone Number:	Moms Cell Number: Dads Cell Number:	
Email Address:			
Other Family Members & DOB's Seen here:			
Choose office/referred by: Circle one please	Doctor's office. Dr.	Insurance Plan	Friend / Family
Hospital (if so name)	Close to home or work	Yellow Pages	Other

Insurance Plan

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth Date / /	Address(If Different)	Home Phone:
Occupation:	Employer:	Employers Address:	Employer #
Is this Patient covered by insurance(circle one please) Yes No			
Please indicate insurance(circle one please):	BCBS / IHA / Empire Plan / Fidelis / Aetna		
United Healthcare / Univera / Medicaid / Other:			
ID Number:	Group Number:	Co-Payment:	
Relationship to Patient:	Mother / Father / Other:		
Spouses Name:	DOB: / /	Work Number:	
Relationship to Patient:	Mother / Father / Other:		

IN CASE OF EMERGENCY CONTACT INFORMATION

Name:	Relationship to Patient:	Home/Cell Number:

This above information is true to the best of my knowledge. I authorize my insurance benefits be paid to the physician. I understand that I am financially responsible for any balance. I also authorize Williamsville Pediatric Center/ Insurance company to release any information required to process my claims:

Signature: Date: