Northport Pediatric & Adolescent Medicine

Patient Name: ______________________ Nickname: ____________ Birthdate: ________ Sex: M /F

DEMOGRAPHIC INFORMATION:

Ethnicity (choose one):
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefers not to answer

Preferred Language: ______________________

Race (Choose one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Prefers not to answer

SIBLINGS:

Other Children's' Names	Birthdate	Sex	Demographics (same as above?)	If different, please specify
1.		M F	Yes No	
2.		M F	Yes No	
3.		M F	Yes No	
4.		M F	Yes No	

ACCOUNT INFORMATION:

Custodian (patient lives with):

Name: ______________________

DOB: ____________ SSN: ____________

Address: ______________________

____

Primary Phone: ______________________

Secondary Phone: ______________________

Email: ______________________

Guarantor (bills sent to):

Name: ______________________

DOB: ____________ SSN: ____________

Address: ______________________

____

Primary Phone: ______________________

Secondary Phone: ______________________

Email: ______________________

Mother's Maiden Name: ______________________

Emergency Contact:

Name:	Relationship:	Phone:

If you would like to receive appointment reminders via text message, please enter a phone number we can text: ________

Would you like to sign up for **My Kid's Chart**, our patient portal, so you can securely view and print your child's medical record online? We will e-mail you the link so you can sign up. [ ] Yes [ ] No

If yes, please provide e-mail and write legibly: ______________________

INSURANCE INFORMATION: Please provide a copy of your current insurance card(s)

Insurance holder's name: ______________________ Date of Birth: _____/_______/______

Employer: ______________________ Phone: ____________

If for any reason the insurance company should refuse payment of the bill, I am legally responsible at the office rate. I hereby authorize payment of medical benefits to Susan Gunduz, M.D.

Signature ______________________ Date ____________