

# Siena Pediatrics

*Carrie Wijesinghe, MD*

*Charlotte Lee, MD*

*Lisa Glasser, MD*

*Lillie Hidaji, MD*

*Randi Carrozza, FNP*

**Patient's Name:** \_\_\_\_\_ Date of birth \_\_\_\_\_

(Circle one) Male/Female Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Address: \_\_\_\_\_ Apt. No: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No: \_\_\_\_\_ Cell: \_\_\_\_\_ Preferred language: \_\_\_\_\_

**Father's/Guardian's Name:** \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address: \_\_\_\_\_ Apt. No: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone No: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

**Mother's/Guardian's Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. No. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone No: \_\_\_\_\_ Relation to Patient \_\_\_\_\_

**\*Email Address \_\_\_\_\_ for either parent**

**Emergency Contact:** \_\_\_\_\_ Phone No: \_\_\_\_\_

**It is very important that you fill out the insurance portion in its entirety. If it is incomplete, you may be liable for services rendered that return unpaid due to insufficient information.**

### **Primary Insurance**

Primary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

S.S.#/I.D.#: \_\_\_\_\_ GroupNo: \_\_\_\_\_ Policy #: \_\_\_\_\_

### **Authorization To Release Information & Assignment of Benefits**

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company to **Wijesinghe Pediatrics PC DBA**. We will gladly file your insurance claim, however payment for co-pays and deductibles are required at the time services are rendered. We cannot guarantee payment to **Wijesinghe Pediatrics PC DBA**. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will be responsible for all amounts not covered payable to **Wijesinghe Pediatrics PC DBA**. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency.

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_