Pediatric Endocrinology of New York PC

Registration Form

First Name		Middle Name	Last Name	
Sex	Date of Birth	Cell Number	Other Number	
Address		City	State	Zip Code

Please sign if you agree to receive confidential voice mails to the phone numbers provided.

Number where its ok to leave messages: _____

Signature and Initials

Signature _____ Initials_____

Ethnicity	Race	Preferred Language
Pharmacy	Pharmacy Address	Pharmacy Phone Number

How may we contact you? Select all that apply ☐Mail ☐Text ☐Phone ☐Email

Email Address	Phone number we can text

Primary Medical Insurance

Name of Subscriber **(Must have name, DOB to bill)**	**D.O.B**

Pediatrician or Referring Doctor:

Please note test results will only be discussed in the office during the time of the appointment. No results will be discussed over the phone

Agreement to pay for treatment

I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office had a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. I further understand that if I do not show for an appointment or do not give a 24 hour notice to Pediatric Endocrinology of New York PC when cancelling an appointment I may be responsible for the charges up to the potential cost of the visit. The charge for a **No Show** without notice given 24 hours prior to the appointment is $50.00. Your signature also acknowledges you received the Notice of Privacy Practices.

_____ _____

Responsible Party Signature Date