STAMFORD HEALTH
Healing. Reimagined.

Affiliate: Columbia University College of Physicians and Surgeons
A Planetree Hospital
A Magnet® Recognized Hospital

____Update _____New Patient

Today's Date: __________/ _______/________

Patient Name: ____

Date of Birth:_______/_______/_______ M ____ F_____

***Please check one of each category below**

Race: Refused to Report____ Undefined____ American Indian____ Asian____ Black/African American____ Native Hawaiian or Pacific Islander _____White_____

Ethnicity: Hispanic or Latino_________ Not Hispanic or Latino_________ Refused to report/unreported_________

Language: ____

Birth place: ____ State or Country: ____

Patient Name: ____

Date of Birth:_______/_______/_______ M _____ F______

***Please check one of each category below**

Race: Refused to Report_____ Undefined_____ American Indian_____ Asian_____ Black/African American____ Native Hawaiian or Pacific Islander ____White____

Ethnicity: Hispanic or Latino_________ Not Hispanic or Latino_________ Refused to report/unreported_________

Language: ____

Birth place: ____ State or Country: ____

Address: ____ City: __________________ State: ____________________ Zip: ________________

Home #:____ Primary E-Mail: ____

Parent Name: ____

Address: ____________________City: ________ State: ____ Zip: ____

Cell #:______________________ Work #:______________________

Employer: ____________________ Occupation: __________________

D.O.B.: ______/______/______

Parent Name: ____

Address: ________________________________City: ________ State: ____ Zip: _____

Cell #:____________________________ Work #:_______________________________

Employer: ___________________________ Occupation: _________________________

D.O.B.: ______/______/______

INSURANCE INFORMATION – YOU MUST PROVIDE US WITH A COPY OF YOUR CURRENT INSURANCE CARD/S

Primary Policy Holder: __________________________________

Insurance Co.: ____

Policy#:____

Group#:________________________Co-Pay___________________

Relationship to Patient: _____________________________________

Insurance through: Employer ______ Self Pay ______ Other______

Secondary Policy Holder : ____

Insurance Co.:____

Policy #:____

Group #: ____________________________Co-Pay___________________________

Relationship to Patient: ____

Insurance through: Employer ______ Self Pay ______ Other______

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS: I authorize Stamford Health Medical Group Pediatric Center, to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms school & camp forms. I authorize payment directly to SHMG Pediatric Center, for any and all medical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse SHMG Pediatric Center for any payments my insurance company may have sent to me in error. Understand that I am financially responsible for all co-payments and any charges not covered under my benefits. I also, understand that I am responsible for advising SHMG Pediatric Center for any and all changes to my address and/or insurance

Signature: ____ Relationship to Patient(s):___________________________ Date: _______/ _______/_________