GREECE PEDIATRIC MEDICINE PLLC

Greece Pediatric Medicine, PLLC
3208 Latta Road, Suite 10
Rochester, NY 14612
Phone: 585-504-6504
Fax: 585-504-4923

Patient Information

Last Name: First Name: MI:

Date of birth: Sex: Female Male Gender Identity:

Primary Phone: Primary email address:

Primary Street Address:

City: State: Zip:

What race do you identify with:

African American American Indian or Native Alaskan Asian Hawaiian or Pacific Islander

White Prefer not to say Other

What ethnicity do you identify with:

Hispanic/Latino Non-Hispanic/Latino Unknown Prefer not to say Other

Preferred Language:

Insurance Information

Insurance: ID Number:

Subscriber: Subscriber Date of Birth:

Pharmacy Information

Pharmacy Name: Phone number:

Street Address: City:

School Information

School Name:

Family Information

Parent/Legal Guardian 1

Last Name: First Name:

Relationship to patient: Lives with patient? Yes No

Address: City: State: Zip:

Home phone: Cell phone: Work phone:

Best contact number: Home Cell Work Email address:

Employer: Occupation:

Greece Pediatric Medicine , PLLC may contact me via: Home Cell Work Email

Greece Pediatric Medicine, PLLC may leave messages and lab results via: Home Cell Work Email

Parent/Legal Guardian 2

Last Name: First Name:

Relationship to patient: Lives with patient? Yes No

Address: City: State: Zip:

Home phone: Cell phone: Work phone:

Best contact number: Home Cell Work Email address:

Employer: Occupation:

Greece Pediatric Medicine, PLLC may contact me via: Home Cell Work Email

Greece Pediatric Medicine, PLLC may leave messages and lab results via: Home Cell Work Email

Who should receive billing statements?

May all contacts have access to patient records? Yes No

If no, please list who may have access:

Child's parents are: Married Divorced Separated Widow(er) Other

If parents are divorced, separated or not married please complete the following section.

Who has custody of the child(ren)?

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child(ren)?

☐ Yes ☐ No

If yes, please explain and provide a copy of legal paperwork supporting this restriction.

Additional Emergency Contacts (other than parents)

Last Name: First Name:

Phone number: Relationship:

Last Name: First Name:

Phone number: Relationship:

Siblings:

Last Name: First Name:

Last Name: First Name:

Last Name: First Name:

Last Name: First Name: