Happy and Healthy Pediatrics, PC
Elissa Rubin, MD FAAP
Deborah Saunders, MD FAAP, FSHAM

Patient Registration Form

Patient

Patient's Full Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Patient's Address_____ Patient's Home Tel# _____ -- _____ -- _____

City, State, Zip _____

How did you hear about our practice? / I was referred by: _____

Family's main e-mail address: _____

Insurance Carrier and Primary Card Holder: _____ _____

Siblings

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Sibling's Name _____ M ☐ F ☐ Date of Birth _____ / _____ / _____

Mother ☐ Lives with Patient

Mother's Full Name _____ Mother's Work Tel # _____ -- _____ -- _____

Mother's Maiden Name _____ Mother's Cell Tel # _____ -- _____ -- _____

Mother's Address (if differs from above): Mother's Date of Birth _____ / _____ /_____

Mother's Employer / Occupation _____

_____

_____

Father ☐ Lives with Patient

Father's Full Name _____ Father's Work Tel # _____ -- _____ -- _____

Father's Address (if differs from above): Father's Cell Tel # _____ -- _____ -- _____

Father's Date of Birth _____ / _____ / _____

_____ Father's Employer / Occupation _____

_____

Emergency Contact

Contact's Full Name _____ Contact's Relationship to Patient _____

Contact's Tel # (1st) _____ -- _____ -- _____ Contact's Tel # (2nd) _____ -- _____ -- _____

Authorizations and Consents:

☐ (**Please check**) I authorize treatment of the patient named above, and all siblings listed, by Happy and Healthy Pediatrics, PC. I authorize the release of medical records necessary to process insurance claims and to other medical providers involved in my child's/children's care. I authorize payment of medical benefits to be made directly to Happy and Healthy Pediatrics, PC.

☐ (**Please check**) I have been presented with a copy of the Notice of Privacy Practices for the office of Happy and Healthy Pediatrics, PC detailing how my information may be used and disclosed as permitted under federal and state law.

Yes / No I would like to receive updates, messages relating to my child's healthcare, general office information, etc. via e-mail.

Signature _____ Date _____ /_____ / _____

Name (Print) _____ Relationship to patient (circle one): Mother Father Legal Guardian

77 Jericho Turnpike Suite 175 Mineola, NY 11501
Phone: 516-216-5910 Fax: 516-216-5907
www.happyandhealthypediatrics.com