BEL AIR/HDG PEDIATRIC CENTERS

RASTOGI, YIM, WINKLE, M.D. & DRUYOR, FNP-C

PATIENT INFORMATION SHEET

Mother or Guardian's FULL Name_____

Mother's Maiden Name_____D.O.B._____

Home Address(Street, City, State)_____Zip_____

Employer_____Address_____

Social Security #_____

Father or Guardian's Name_____D.O.B._____

Home Address(Street, City, State)_____Zip_____

Employer_____Address_____

Social Security #_____

Phone numbers: Father's name Mother's name

Home #_____ Home #_____ please #1-3 of order for us

Day #_____ Day # _____ call concerning

Alternate #_____ Alternate #_____ appointments or results.

Cell phone #_____ Cell phone #_____

One parent's email address for the portal system_____

Preferred Pharmacy Name_____

Pharmacy Location_____

LIST ALL CHILDREN (given name or name shown on insurance card if different)

Last Name, First Name	Date of Birth	M/F	Social Security #	Race
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

INSURANCE INFORMATION

Primary insurance name_____policyholder_____

Secondary insurance name_____policyholder_____

I authorize the release of any medical information necessary to process claims for payment of medical charges. I also authorize payment of medical benefits to Drs. Rastogi, Yim & Winkle and NP Druyor for services rendered. I understand that all services rendered on a payment for services basis. If collection becomes necessary, the undersigned shall pay all costs including attorney's fees.

Parent/Guardian/Self_____Date_____