Mohammad Djafari Pediatric
15-17 Kennedy Parkway, Cortland, NY 13045
Ph# (607) 753-3051 Fax# (607) 753-7735
Email: djafaripediatrics@gmail.com

Patient Information ***(Please list all children)***

Name:_____ ***Male/Female Date of Birth:***_____
Name:_____ ***Male/Female Date of Birth:***_____
Name:_____ ***Male/Female Date of Birth:***_____
RACE: White_____ African American_____Asian_____Hispanic_____Other_____
Patient Address: *Street_____City_____State_____Zip_____*
County of Residence:_____HM#_____Cell#_____

INSURANCE INFORMATION

Primary Insurance:_____ID#_____
Subscriber's Name:_____SS#_____DOB_____
Secondary Insurance:_____ID#_____
Subscriber's Name:_____SS#_____DOB_____

Guardian Information:

Father's Name:_____ DOB_____
Home Ph#:_____Cell#_____ ***SS#_____***
Address: Street_____City_____State_____Zip_____
Employer:_____Ph#_____
Mother's Name:_____DOB_____
Home Ph#:_____Cell#_____ ***SS#_____***
Mother's Maiden Name_____
Address: Street_____City_____State_____Zip_____
Employer:_____Ph#_____

Appointment/Results Notifications:

Home_____Mobil_____Text ***(for appt confirmation)*** *_____Work_____W/another person_____Via mail_____Email_____*

IN CASE OF AN EMERGENCY, or inability to contact parent, Dr. Djafari's office may contact, and leave information with (any person other than parent)

Name:_____ Relationship to Patient_____
Hm Ph#:_____Cell#_____

I hereby give assignment of benefits to the Doctor of this office for the collection of fees for service(s) rendered to me under his care. I wish all payments go directly to him to credit my account. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse any co-issued payments for the conveyance of credit to my account. If for any reason this insurance company disregards my request, I understand that I am responsible for the payment for services rendered. I hereby authorize any Doctor, Hospital, Employer or other person to whom a signed photocopy of this authorization is delivered, to furnish any information, reports, or copies of records, which may be requested by Dr. M. Djafari. I understand and agree that any credit shall be paid promptly in accordance with terms and agreements and that the credit grantor may add one and half percent (1.5%) per month to any balance owed, and in the event of default, to pay reasonable collection charged and/or attorney. ***A HIPPA Privacy is available to you upon request, and a copy of this notice can be found posted in our waiting area.*** *By signing this information sheet I agree to the terms and uses of the HIPPA Privacy Notice, and to the* ***terms of billing****.*

Guardian Signature:_____Date_____
Relationship to Patient:_____
Patient Signature (18+):_____Date_____