



*KidsCare
Pediatric*

M E D I C I N E , P . C .

Boris Lustik, M.D.
Anna Schwartz, M.D.
Amy Leonard, M.D.

Phone: **631-698-0600**
Fax: **631-698-2212**

Patient Information

Patient Name: _____

Patient Address: _____

Town: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Sex: _____

Mother's Name: _____ Birth Date: _____

Employer: _____ SS#: _____

Father's Name: _____ Birth Date: _____

Employer: _____ SS#: _____

Person Responsible For Payment (Insured): _____

Address (if different from above): _____

Town: _____ State: _____ Zip: _____

Home Phone: _____

I hereby authorize the release of any information acquired in the course of my child's examination and treatment to my insurance company.

I hereby authorize payment to Drs. Lustik, Schwartz and Leonard, for the surgical/medical benefits due under the terms of my insurance.

I hereby attest that the insurance information including PCP and COPAY shown below is true, accurate and in effect on the dates I attest to. If not, I will be responsible for payment.

Date: _____ Sign: _____ Date: _____ Sign: _____

Date: _____ Sign: _____ Date: _____ Sign: _____

Date: _____ Sign: _____ Date: _____ Sign: _____

Date: _____ Sign: _____ Date: _____ Sign: _____

Date: _____ Sign: _____ Date: _____ Sign: _____

Date: _____ Sign: _____ Date: _____ Sign: _____



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Selden, New York 11784

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