Town and Country Pediatrics and Family Medicine, PC
380 Main Street, Watertown, CT 06795
860-274-8891(phone) 860-274-8895(fax)

***** PLEASE CIRCLE A PREFERRED PROVIDER*****
Dr. Jacqueline Lustig Dr. Ephraim Bartfeld
Erin Floridia, PA-C Sabrina Lachowicz, PA-C

Patient Name: Last_____ First_____Middle_____
Patient Date of Birth: _____ Marital Status: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Email Address for Patient Portal (If desired) :_____
Home Phone: _____Can we leave a message? Yes/No
Work Phone: _____Can we leave a message? Yes/No
Cell Phone: _____Can we leave a message? Yes/No
Occupation: _____Place of Employment: _____

PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN PARENT):
NAME: _____ PHONE NUMBER: _____

PREFFERED PHARMACY: _____

It is recommended by the National Committee on Quality Assurance that we ask you the following information so that we can provide you with better care:

Preferred Language: (circle one) ENGLISH OTHER_____ DECLINE
Race: (Circle one) CAUCASIAN BLACK ASIAN NATIVE- AMERICAN PACIFIC-ISLANDER DECLINE
Ethnicity: (Circle one) HISPANIC NON-HISPANIC DECLINE
Visual Impairments? Yes/No **Hearing Impairment?** Yes/No

Patient insurance (Name of insurance company):_____
Patient insurance policy number:_____
Patient insurance group number:_____
Subscriber name:_____
Subscriber D.O.B:_____
Subscriber relationship to patient:_____
Secondary Insurance (Name of insurance company):_____
Secondary insurance policy number:_____
Secondary insurance group number:_____
Subscriber name:_____
Subscriber D.O.B:_____
Subscriber relationship to patient:_____

The following section below is for pediatric patients only:

MOTHER'S NAME: _____
MOTHER'S DOB:_____
ADDRESS: _____
CITY: _____
ZIP: _____
CAN WE LEAVE A MESSAGE?
Home Phone: _____ Y/N
Work Phone: _____Y/N
Cell Phone: _____Y/N
Occupation:_____ Y/N
PLACE OF EMPLOYMENT:_____

FATHER'S NAME: _____
FATHER'S DOB: _____
ADDRESS: _____
CITY: _____
ZIP:_____
CAN WE LEAVE A MESSAGE?
Home Phone: _____Y/N
Work Phone: _____Y/N
Cell Phone: _____ Y/N
Occupation:_____ Y/N
PLACE OF EMPLOYMENT:_____

NAMES OF SIBLINGS AND DATE OF BIRTH:

_____

_____

_____

FOR ALL PATIENTS, PLEASE REVIEW AND SIGN BELOW:

Responsibility for payment:

I acknowledge and understand that the patient's insurance may not cover all costs and expenses relating to the treatment and services the patient receives, and that certain services may have a co-payment or may not be covered by the patient's insurance plan. I also acknowledge that additional costs related to certain after-hours of Sunday appointments may not be covered by insurance, and that I may have responsibility for additional payments for those appointments. I specifically agree to be responsible for any amount not paid by the insurance or ay amount(s) not paid due to failure to follow the procedures required to be performed by me (or the patient) per the insurance plan. I agree to make such payments within 45 days from billing by the practice, and in the event the account is not paid in full within that time, I will reimburse the practice for all costs of collection, including reasonable attorney fees together with the interest charges.

SIGNATURE OF PATIENT/PARENT IF MINOR: _____DATE:_____

Authorization and release:

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such care to third party payers and/ or other health practitioners. I authorize and request my insurance company to pay directly to the doctor Insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf.

SIGNATURE OF PATIENT/PARENT IF MINOR: _____DATE:_____