E.G.GREENPOINT PEDIATRICS
14 McGUINNESS BLVD. SOUTH
BROOKLYN NY 11222
PHONE: 718-349-0671
FAX: 718-349-9511

Last Name______________________________**First Name**____________________________**F**______**M**______
Nazwisko Imie

Patient's DOB mm ____________**dd** ____________**yyyy** ______________
Data urodzenia pacjenta

Best tel. number ______________________________________ ______________________________________
Numer telefonu FATHER MOTHER

Address____**Apt#**________

____
City State Zip Code

Race ______________**Ethnicity**______________**E-Mail** ____

Pharmacy where you go to ____
Apteka **Name and tel. nr.**

Mother's Name ________________________________**Father's Name**____________________________________

Primary Insurance ____
Nazwa ubezpieczenia

Insurance ID# ____
Nr ubezpieczenia

Full name of policy holder ____
Imie I nazwisko osoby ubezpieczajacej

DOB and SS of policy holder ____
Data urodzenia I SS osoby ubezpieczajacej

Allergies ____
Uczulenia, alergie

Signature ____**Date**________________________
Podpis i data

I hereby consent to the provision of care, vaccination administration, diagnosis and/or treatment by E.G Greenpoint Pediatrics. I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.
The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical care for a minor in the event of emergency and/or for routine medical treatment for symptoms of illness (e.g. fever, cough, irregular breathing, unusual rash, sore throat etc) and wellness visits.
I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of care, vaccination administration, diagnosis and/or treatment.

Signature ____**Date**________________________
Podpis i data