30 Amsterdam Ave,
Amherst, NY 14226
716-837-7424

COMMUNITY PEDIATRICS OF WNY

LUBNA S. GURU MD

741 Davison Road
Lockport, NY 14094
716-433-6666

PATIENT INFORMATION SHEET

Last Name: _____ Date: _____

Address: _____ City: _____

ZIP Code: _____ Phone: _____ Email: _____

Father's Information

Father's Name: _____ Date Of Birth: _____

SS#: _____ Employer: _____

Employer's Address: _____ Phone: _____

Mother's Information

Mother's Name: _____ Date Of Birth: _____

SS#: _____ Employer: _____

Employer's Address: _____ Phone: _____

Child's Information

Name: _____ Date Of Birth: _____

Gender: ☐ Male ☐ Female SS#: _____

General Information

Pharmacy: _____

Whom do we notify in case of emergency? _____

Relationship: _____ Phone: _____

Insurance Information

Insurance Company: _____

Insurance Company Address: _____

I.D. # _____ Group # _____ Eff. Date: _____

Subscriber's Name/Address (if different from above): _____

Assignment & Release:

I hereby authorize Dr. Guru to furnish any necessary information to insurance carriers concerning my condition and treatment required to process the claim for services. I hereby authorize my benefits/payments to be paid directly to Dr. Guru and I am financially responsible for non-covered services.

Signature of Insured: _____ Date: _____