Buckley Road Pediatrics, PLLC

If you are a New York State Medicaid Member, there is a new statewide Program starting January 1, 2025, focused on meeting your health-related social needs, called the Social Care Network (SCN) Program.

(This program has a main focus on medicaid but there are still some resources that those with private insurance can still utilize)

Below you will find a QR Code that will bring you to the information about the Social Care Network (SCN) and Health Related Social Needs (HRSN).	Below you will find a QR Code that will bring you directly to the Screening tool that you can fill out through Healthy Alliance.
https://www.healthyalliance.org/member/	https://www.healthyalliance.org/screening/

Signature_____ Date_____/_____/_____

BUCKLEY ROAD PEDIATRICS

Patient Demographic Information:

Patient's First Name:_____**Last Name:**_____

DOB:_____**Sex assigned at birth:** Male / Female

Cultural Demographics:

Race: ○African American ○Asian ○Pacific Islander ○White ○Other_____

Ethnicity: ○Hispanic ○Non-Hispanic ○Prefer not to specify

Parent Information:

Mother / Father / Guardian:

First Name:_____**Last Name:**_____

Maiden Name:_____**DOB:**__/__/_____

Address:_____

City:_____**State:**_____**Zip:**_____

Primary Phone: (____)____-_____ Home / Cell / Work

Secondary Phone: (____)____-_____ Home / Cell / Work

Employer: _____

Mother / Father:

First Name:_____**Last Name:**_____

Maiden Name:_____**DOB:**__/__/_____

Address:_____

City:_____**State:**_____**Zip:**_____

Primary Phone: (____)____-_____ Home / Cell / Work

Secondary Phone: (____)____-_____ Home / Cell / Work

Employer: _____

Who does the Patient primarily live with? (please check one)

○Mother ○Father ○Both ○Guardian

PLEASE FILL OUT AND SIGN BACK SIDE

Pharmacy Information:

Primary:
Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone: (___)___-_____

Secondary: (optional)
Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone: (___)___-_____

Insurance Information:

Primary:
Insurance Name:_____**ID#:**_____
Subscriber Name:_____**DOB:**__/__/_____
Employer:_____

Secondary: (optional)
Insurance Name:_____**ID#:**_____
Subscriber Name:_____**DOB:**__/__/_____
Employer:_____

Emergency Contact:

If you wish to have an emergency contact please put someone not listed on page 1.

First Name:_____**Last Name:**_____

Primary Phone: (___)___-_____ Home / Cell / Work

Secondary Phone: (___)___-_____ Home / Cell / Work

Relation:_____

By signing below I hereby authorize the above information is accurate:

_____ _____
Signature of Patient or Legal Guardian Date:

****IF THIS DOCUMENT IS NOT SIGNED IT WILL BE CONSIDERED AN INVALID DOCUMENT AND WILL NOT BE ENTERED INTO THE CHART****

Authorization to share medical information:

Patient Name:__________________________________ Date of Birth:___/___/______

Legal Guardian:____

Legal Guardian:____

- The above patient is receiving care at Buckley Road Pediatrics, PLLC. This authorization is valid at Buckley Road Pediatrics 5116 W Taft Rd Liverpool, NY 13088 until revoked or modified at any time by myself/legal guardian in writing and won't affect any release prior to modification or revocation of this authorization.
- I hereby authorize Buckley Road Pediatrics to share information regarding my/my child's medical care with the individual(s) that are over the age of 18 and to the degree that I have specified below.
- I understand that this authorization may be revoked in writing at any time and that this revocation will be honored with the exception of any previous requests processed.

I authorize the following individual:___________________________________to:
(name and relation)

____Discuss medical treatment/Bring to appointments ____Discuss billing/collection issues
____Pick up any copies of medical records ____Schedule/Modify appointments
Phone#:_______________ [ ] Leave call back number only [ ] Leave full detailed message

I authorize the following individual:___________________________________to:
(name and relation)

____Discuss medical treatment/Bring to appointments ____Discuss billing/collection issues
____Pick up any copies of medical records ____Schedule/Modify appointments
Phone#:_______________ [ ] Leave call back number only [ ] Leave full detailed message

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____Pick up any copies of medical records ____Schedule/Modify appointments
Phone#:_______________ [ ] Leave call back number only [ ] Leave full detailed message

By signing below I hereby authorize to share the above information

____ _____________

Signature of Patient or Legal Guardian Date: