Welcome to the Office of Rajesh Mariwalla M.D. PC

MARIWALLA Pediatrics

1175 Montauk Highway, Suite 4
West Islip, New York 11795
P: 631-422-9600 F: 631-422-9697

1111 Montauk Highway, Suite 104
West Islip, New York 11795
P: 631-661-2510 F: 631-669-6502

	Last Name	First name	DOB	Birth Sex	Preferred Gender	Pronouns
1				☐ M ☐ F	☐ M ☐ F	☐ She ☐ He ☐ They
	Cell number if over 18 years of age:			Preferred first name if applicable:		
2				☐ M ☐ F	☐ M ☐ F	☐ She ☐ He ☐ They
	Cell number if over 18 years of age:			Preferred first name if applicable:		
3				☐ M ☐ F	☐ M ☐ F	☐ She ☐ He ☐ They
	Cell number if over 18 years of age:			Preferred first name if applicable:		
4				☐ M ☐ F	☐ M ☐ F	☐ She ☐ He ☐ They
	Cell number if over 18 years of age:			Preferred first name if applicable		

Language:_____ Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unknown ☐ Decline to specify
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African Am ☐ White ☐ Hawaiian Native/Pacific Islander ☐ Decline to specify

Parent/Guardian 1 Information: Relationship to patient (Pick One): ☐ Mother ☐ Father ☐ Other:_____
Last name: _____ First name: _____ MI: _____ Sex: ☐ M ☐ F
Address: _____ City: _____
State:_____ Zip: _____ Email: _____ DOB: _____
Cell Phone:_____ Home Phone: _____ Work Phone: _____
Employer:_____ Maiden Name (if applicable): _____

Parent/Guardian 1 Information: Relationship to patient (Pick One): ☐ Mother ☐ Father ☐ Other:_____
Last name: _____ First name: _____ MI: _____ Sex: ☐ M ☐ F
Address: _____ City: _____
State:_____ Zip: _____ Email: _____ DOB: _____
Cell Phone:_____ Home Phone: _____ Work Phone: _____
Employer:_____ Maiden Name (if applicable): _____

Who does the child live with? ☐ Lives with biological parents ☐ Lives with Adoptive Parents ☐ Joint Custody ☐ Single Custody
☐ Lives with Foster Family ☐ Other: _____

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?
_____

Primary Pharmacy Information:
Pharmacy Name and Town: _____ Pharmacy Phone Number: _____

Primary Insurance Information:
Insurance Company Name: _____ Policy Holder: _____
Insurance ID#:_____ Group#: _____

Secondary Insurance Information: Please provide to staff if applicable.

Emergency Contact Information (OTHER THAN PARENT 1 OR PARENT 2):
Contact Name: _____ Cell Phone: _____
Home: _____ Relationship to Patient(s): _____

Please turn over and sign

Updated August 2026

Assignment of Benefits/Authorization/Notice of Collection Action
I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid Insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, fees for in-office services and/or tests, and any fees Incurred should my account require collection action. (E.G., late fees, collection agency, court or attorney costs).
medical care or in the processing applicants' financial benefit.
Also, please be advised our office may contact you via an automated system, or text message, regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing.

New York State vaccine Registry (If applicable)
Please be advised that our office submits confidential data of children and adult vaccinations to the NYSIIS (New York State Immunization Information System) per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record of a patient's immunization history.

Authorization To Release Information:
I hereby authorize this practice, to release any medical or incidental information that may be necessary for either medical care or in the processing applicants' financial benefit.

Notice of Privacy Practices: Patient Acknowledgement
I have received this practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health Information that may be made by this practice's legal duties with respect to my Information. I understand the practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information. I understand I can obtain the practice's current Notice of Privacy Practices on request.

Signature Required
The undersigned acknowledges that I have read and understand the above terms and conditions.

_____
Guarantor/Parent/ Guardian completing this form (Please Print)

_____
Signature

_____
Date