Beachside Pediatrics LLC
Robin Straus Furlong M.D.
Sandy Lieberman M.D.
1145 Kane Concourse
Bay Harbor Islands, FL 33154
OFFICE: (305) 865-5439
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PATIENT INFORMATION AND EMERGENCY MEDICAL CARE AUTHORZATION

Patient's Name_____ Date of Birth_____

Address_____City_____State__Zip_____Phone( )_____

Parent's Name _____Date of Birth_____SSN_____

Parent's Name_____Date of Birth_____SSN_____

Other children coming to our office _____

Person Responsible for
Payment_____Email_____

Address_____City_____State__Zip_____Phone( )_____

Mother's Employer_____City_____Phone( )_____

Father's Employer_____City_____Phone( )_____

Cell Phone # Mom # ( )_____ Dad # ( )_____

Insurance Coverage _____Subscriber's Name_____

Member # (ssn)_____Group #_____ Phone # ( )_____

Nearest Relative (other than parent) in case of an emergency_____

Address_____City_____State__Zip_____Phone ( )_____

OB/GYN Doctor (mother's)_____Phone ( )_____

Patient Referred by_____Drug Store Phone #( )_____

Primary Language Spoken _____

EMERGENCY CARE AUTHORZATION

I authorize Robin Straus-Furlong M.D. or Sandy Lieberman M.D. to perform any necessary emergency Care for my child, named above, if I am unable to be located at the time of need for such care.

Signed_____ Date_____ Relationship to Patient_____