GARBIS GARY BAYDAR, M.D., F.A.A.P.
MELISSA DAVIDSON, M.D., F.A.A.P.
CINDY W. TUNG, M.D., F.A.A.P.
PEDIATRIC & ADOLESCENT MEDICINE

370 Grand Avenue
Suite 203
Englewood, NJ 07631
Phone: 201.568.3262
Fax: 201.569.2634

New Patient Form

Dear Parent/legal representative:

Please make sure to bring with you all of your health insurance information at the time of your appointment. This information includes your insurance company, policy #, group #, policy holder SSN # and the Patient Agreement form (download from our New Patient web page).

How did you hear about us?

☐ Physician _____ ☐ Family/Friend _____

☐ Insurance Directory ☐ Internet

Patient Name _____ Date Of Birth _____

☐ Male ☐ Female Allergies _____

_____

Address_____ City_____

State____ Zip_____ Phone_____

Cell (Mother)_____ Cell (Father)_____

Father's Name_____ Date Of Birth_____

Employer_____ Allergies_____

_____

Work Address_____ City_____

Address (if different than child)_____

State____ Zip_____ Phone_____

Email Address_____

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Mother's Name_____ Date Of Birth_____

Employer_____ Allergies_____

_____

Work Address_____ City_____

Address (if different than child)_____

State____ Zip_____ Phone_____

Email Address_____

Siblings Names_____ _____ _____

Siblings DOB_____ _____ _____

Siblings _____ _____ _____
Allergies

_____ _____ _____

Emergency Contact_____ Relationship_____

Phone Number_____

Who receives the bill (other than co-payment)?

Policy Holder_____ Policy Holder SSN_____ _____ _____

Relationship_____ Insurance Company_____

Policy number_____ Group Number_____

Co-Pay Amount ($)_____ Does Policy Require Referrals? ☐ YES ☐ NO

Pharmacy Phone Number_____

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Assignment of Benefits: I, the undersigned request that payment of all insurance benefits payable for medical services provided, be made directly to the physician. In addition, I authorize the release of any medical information as permitted by the law necessary to process a health insurance claim form.

☐ I Accept The Terms Name_____ Date_____

I do hereby acknowledge that I was informed that in the event that my healthcare insurance plan denies payment for my services received I agree to be personally responsible for the payment of these services. It is therefore my responsibility to contact my insurance carrier to confirm coverage provisions.

☐ I Accept The Terms Name_____ Date_____

Please be advised that this office reserves the right to charge $50 for failure to appear for an appointment without a prior 24-hour notice of cancellation.

☐ I Accept The Terms Name_____ Date_____

Signature_____