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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 _____