The Pediatric Center

Patient Registration

Parent/Guardian 1 Information: **Relationship to patient (circle one) Mother Father Other:** _____

Last name:_____ First name:_____ MI:_____ Sex: M / F

Street Address:_____City: _____

State:_____ Zip:_____ Email: _____Date of Birth: _____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

SS#: _____ **Preferred Contact For Appointment Reminders:** text to cell ☐ call to home ☐

Parent/Guardian 2 Information: **Relationship to patient (circle one) Mother Father Other:** _____

Last name:_____ First name:_____ MI:_____ Sex: M / F Street

Address:_____City:_____

State:_____ Zip:_____ Email:_____ Date of Birth: _____

Cell phone:_____ Home Phone:_____ Work Phone:_____

Parents are: Married / Single / Divorced (please circle)

Primary Insurance Information:

Insurance Company Name: _____ **Name of Insured**: ☐ Parent 1 ☐ Parent 2

Street Address: _____ City, State, Zip: _____

SS# of Insured: _____ ID #: _____ Group #: _____

Secondary Insurance Information:

Insurance Company Name: _____ **Name of Insured**: ☐ Parent 1 ☐ Parent 2

Street Address: _____ City, State, Zip: _____

SS# of Insured: _____ ID #: _____ Group #: _____

Emergency Contact Information:

Contact Name: _____ Cell Phone: _____ Home:_____

Relationship to Patient: _____ Comment: _____

Patient and Sibling Information:

Name:_____ Date of Birth: _____Sex: M / F

Name:_____ Date of Birth: _____Sex: M / F

Name:_____ Date of Birth: _____Sex: M / F

Name:_____ Date of Birth: _____Sex: M / F

Name:_____ Date of Birth: _____Sex: M / F

Name:_____ Date of Birth: _____Sex: M / F

How did you hear about The Pediatric Center (check one below):

Google search: _____ FaceBook: _____ NJTopDocs: _____ NJ Family: _____ Our Baby Class :_____ Other: _____

Name of Referring Physician:_____

Name of Referring Friend or Family: _____

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).

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.

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for the purposes of patient identification.

New Jersey Vaccine Registry (if applicable)

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

Signature Required

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

_____

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

_____

Date

_____

Guarantor/Parent/ Guardian Signature Date