

ESSEX PEDIATRICS REGISTRATION FORM

Patient Name:(First)_____ (Last)_____
Address:(Street)_____, (apartment number)_____
(City)_____, (State)_____, (Zip code)_____
Phone: (home)_____ (work)_____ (cell)_____
Date of Birth:(Month/Date/Year)_____ **Age:**_____
Male_____ Female_____ **Social Security Number:**_____-_____-_____
Emergency Contact:_____ **Phone:**_____

GUARANTOR INFORMATION:

Name:_____ **Relationship to patient:**_____
Address:_____ **Home Phone:**_____
Social Security #:_____
Employer: Company Name:_____ Work Phone:_____
Address:_____ Occupation:_____

PRIMARY INSURANCE: WE NEED TO SEE INSURANCE CARD

Company Name:_____ **Policy Number:**_____
Subscriber's Name:_____
Subscriber's Date of Birth:_____ **Relationship to patient:**_____
Ref# for adding your newborn to your insurance policy: _____

SECONDARY INSURANCE: WE NEED TO SEE INSURANCE CARD

Company Name:_____ **Policy Number:**_____
Subscriber's Name:_____
Subscriber's Date of Birth:_____ **Relationship to patient:**_____

RELEASE AND ASSIGNMENT: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Blue Shield, HMO plans and Commercial Insurance to Essex Pediatrics. I understand that I am financially responsible for all charges whether or not covered by said insurance. I hereby authorize said assignee to release any information necessary to secure payment on my behalf. If Insurance company makes payment to me, I agree to endorse check to Essex Pediatrics.

I also agree to have my child participate with the NJ Immunization Information System. I understand that it is free, it will keep a central electronic record of my child's vaccines, and information may be shared with authorized medical providers/schools/public health agencies as permitted by New Jersey laws.

Signature:(parent/guardian)_____ **Date:**_____

REMINDER NOTICE: I agree to receive appointment reminders via the email or on cell phone listed below.

Email:_____ **Cell Phone #** _____

HIPAA POLICY: I acknowledge receipt of written notice entitled Essex Pediatrics Notice of Privacy Practice. I understand that is my responsibility to review it carefully.

Signature: (parent/guardian)_____ **Date:**_____

CANCELLATION POLICY:If you can not keep your appointment, please contact our office to cancel within 24 hrs. **Failure to do so will result in a \$30.00 no show fee which is not reimbursable by your insurance company.** I acknowledge that I have read cancelation policy.

Signature:_____ **Date:**_____