NEW PATIENT REGISTRATION

Date:_____ **Patient ID #** _____

PATIENT INFORMATION

LAST NAME: _____ **FIRST NAME:** _____

Date of Birth:_____/_____/_____ **Gender:** ☐ Male ☐ Female **Nickname:** _____

Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone #:(_____)_____

Do you wish to communicate with Healthy Pediatrics of Old Bridge, LLC, by email (appointment reminders, billing information, forms, office information)? ☐ Yes ☐ No. If yes, List Email addres(es) _____

EMERGENCY CONTACT: (other than parents)_____
Relationship to patient: _____
Emergency Phone# (_____)_____

PARENT(S)/LEGAL GUARDIAN INFORMATION

Mother's Last Name _____ First name:_____ Date of Birth_____/_____/_____
Home Phone:(_____)_____ Cell: (_____) _____ Work: (_____) _____
Social Security# _____/_____/_____
Home Address: ☐ Check here if same as above
Street:_____
City:_____ State:_____ Zip:_____
Occupation:_____ Employer:_____
Employer's Address:_____

Fatther's Last Name _____ First name:_____ Date of Birth_____/_____/_____
Home Phone:(_____)_____ Cell: (_____) _____ Work: (_____) _____
Social Security# _____/_____/_____
Home Address: ☐ Check here if same as above
Street:_____
City:_____ State:_____ Zip:_____
Occupation:_____ Employer:_____
Employer's Address:_____

MEDICAL INSURANCE INFORMATION

Is patient covered by insurance? ☐ Yes ☐ No. Please provide us with your insurance card, so we may have a copy on file.

Primary Insurance: _____ Subscriber's Name_____

Subscriber's Date of Birth: ____/_____/_____ Relationship to Subscriber: Self Spouse Child

Policy ID#:_____ Group#:_____

Does the patient have a secondary insurance? ☐ Yes ☐ No

Secondary Insurance: _____ Subscriber's Name_____

Subscriber's Date of Birth: ____/_____/_____ Relationship to Subscriber: Self Spouse Child

Policy ID#:_____ Group#:_____

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by the insurance(s) named in the MEDICAL INSURANCE INFORMATION section of this document may not be confirmed at this time. I wish for my son/daughter to receive medical services from Healthy Pediatrics at Old Bridge, LLC. If it is determined that my son/daughter is not eligible for coverage, I understand that I will be responsible for payment of all services provided.

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF MEDICAL INFORMATION

I hereby assign to Healthy Pediatrics at Old Bridge, LLC any insurance benefits available for health care services provided to my child/children. If these benefits are not assigned to Healthy Pediatrics at Old Bridge, LLC, I agree to forward all health insurance payments that I receive for services rendered immediately to Healthy Pediatrics at Old Bridge, LLC.

I authorize Healthy Pediatrics at Old Bridge, LLC to release the minimum necessary medical or other information to persons employed or retained by or affiliated with Healthy Pediatrics at Old Bridge for purposes of my child/children's diagnosis and treatment that may be required in order to process insurance payment. I agree that these provisions will remain in effect until I provide written notice to Healthy Pediatrics at Old Bridge that this authorization has been changed or discontinued.

FINANCIAL AGREEMENT

- Co-payments – By law, we must collect your insurance carrier co-payment. This payment is expected at the time of visit, prior to services being rendered. Some insurance carriers do not require a co-pay for routine wellness examinations. Only in these cases, co-payment is not expected at the time of visit. Please note that in the event that a child has an additional problem (e.g. ear infection, new injury, etc.) at the time of a wellness visit, an insurance carrier may hold you responsible for a co-payment. In addition, in the event that a parent chooses to have more frequent preventative visits than allowed by the insurance carrier (i.e. separating immunizations), then you may be responsible for a co-payment.
- Appointments – We request 24 hours notice in the event that you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 may then be added to your account.
- Self-Pay Patients – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- Divorced/Separated Parents of Minor Patients – The parent who consents to the treatment of a minor child is responsible for payment of services rendered.
- Bounced Check – Any check made to Healthy Pediatrics at Old Bridge, LLC that is returned due to insufficient funds is subject to a fee of $25.
- We accept payments in the form of cash, check, Visa, Mastercard, or Discover.
- Payment plans can be arranged if you are unable to pay your balance in full.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name