PEDIATRIC MEDICAL GROUP PATIENT INFORMATION

Thank you for choosing our office, in order to provide your healthcare needs accurately and efficiently, the following information is REQUIRED. All information is confidential; a copy of your insurance card will be made and placed in your medical record. All co-payments must be given at the time of service.

Patient Name_____ Date of Birth_____ Siblings Names and DOB_____

_____

Address_____Apt#_____City_____State_____Zip_____

Male___ Female___ Home Phone Number_____ Cell Number_____

Pharmacy Name_____ Pharmacy Phone_____

Referred by_____

Fathers Name_____ Driver's License #_____

Occupation_____SSN_____Cell Phone_____

Mothers Name_____ Driver's License #_____

Occupation_____ SSN_____ Cell Phone_____

Legal Guardian's Name (if other than parent) _____SSN_____

Person to contact in case of an emergency (other then parents):

Name_____ Relationship to Patient_____

Address_____City_____State_____Zip_____Phone_____

PRIMARY INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient_____

Date of Birth _____SSN_____

Insurance Co_____ID#_____Group#_____

Employer _____Work Phone_____

Employers Address_____City_____State_____Zip_____

SECONDARY INSURANCE INFORMATION

Name of Insured _____Relationship to Patient_____

Date of Birth_____SSN_____

Insurance Co_____ID#_____Group#_____

Employer _____Work Phone_____

Employers Address_____City_____State_____Zip_____

ASSIGNMENT OF INSURANCE BENEFITS

I, THE UNDERSIGNED, HEREBY AUTHORIZE PEDIATRIC MEDICAL GROUP OF CENTRAL JERSEY, P.C. TO RELEASE ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BYHALF OF MYSELF AND/OR DEPENTDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS FOR BENEFITS, FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED, ALSO, HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE_____DATE_____

NOTE: A photocopy of this form shall be deemed as valid and effective as the original.