PATIENT REGISTRATION

Formedic

DATE

NAME M F DATE OF BIRTH AGE

STREET ADDRESS CITY STATE, ZIP PHONE ( )

SCHOOL REFERRED BY

FATHER'S NAME OCCUPATION / EMPLOYER DATE OF BIRTH WORK PHONE ( ) S.S. #

MOTHER'S NAME OCCUPATION / EMPLOYER DATE OF BIRTH WORK PHONE ( ) S.S. #

GUARDIAN (OTHER, SELF) OCCUPATION / EMPLOYER DATE OF BIRTH WORK PHONE ( ) S.S. #

EMERGENCY CONTACT (OTHER THAN PARENTS) ADDRESS PHONE ( )

CLOSEST RELATIVES (NOT AT YOUR ADDRESS) ADDRESS PHONE ( )

INSURANCE & BILLING INFORMATION

PERSON RESPONSIBLE ☐ FATHER ☐ MOTHER ☐ RELATIONSHIP

BILLING ADDRESS PHONE #

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY ADDRESS EFFECTIVE DATE

SUBSCRIBER'S NAME I.D. # GROUP # BENEFIT CODE

2) INSURANCE COMPANY ADDRESS EFFECTIVE DATE

SUBSCRIBER'S NAME I.D. # GROUP # BENEFIT CODE

OTHER COVERAGE

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. _____, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT *(please print)* _____ DATE _____

PARENT / GUARDIAN *(please print)* _____ SIGNATURE _____

Initial History: Pediatric or Adolescent Patient

Date ____ / ____ / ____

Patient Name _____ Date of Birth ____ / ____ / ____ Sex: ☐ Male ☐ Female

Health Plan ID # _____ Member # _____

Prenatal History

Weeks gestation at birth _____ Delivery: ☐ Vaginal ☐ C-Section Birth Weight _____ Hospital _____

Past Medical History

Allergies _____ Hospitalizations or Surgery _____

Illnesses _____ Medications _____

Family History

Has any relative had:

	No	Yes	Relationship		No	Yes	Relationship
Alcoholism	☐	☐		Kidney Disease	☐	☐	
Allergies	☐	☐		Lead Poisoning	☐	☐	
Asthma	☐	☐		Mental Illness	☐	☐	
Battered Child	☐	☐		Mental Retardation	☐	☐	
Battered Spouse	☐	☐		Rheumatic Fever	☐	☐	
Cancer	☐	☐		Seizure Disorder	☐	☐	
Diabetes	☐	☐		Sickle Cell Disease	☐	☐	
G6PD	☐	☐		Tuberculosis	☐	☐	
Heart Disease	☐	☐		Drug Abuse	☐	☐	
High Blood Pressure	☐	☐		Early Infant Death	☐	☐	

Social History

Language spoken at home _____

Household: ☐ Mother_____ ☐ Father_____ ☐ Grandmother_____ ☐ Grandfather_____ ☐ Other (specify) _____

☐ Siblings (name, age, sex) : _____

School Grade _____

Behavior Issues _____

School Issues _____

Notes

_____

_____

_____

Signed _____

KIDS KONCEPT PEDIATRICS PA
Nalini Agarwal MD
3250 Route 27
Kendal Park NJ 08824
Tel: 732-398-0900

MHS AmeriChoice