New Jersey Pediatric and Adolescent Care, LLC

Patient Information

Name:_____ Middle: _____ Last:_____ Suffix:_____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M / F DOB: ___/____/____

Home Phone: _____ Mobile: _____

Primary Guarantor Information & Insurance

Name:_____ Middle: _____ Last:_____ Suffix:_____

Address: _____City: _____ State: _____ Zip: _____

SSN: _____-_____-_____ Sex: M / F DOB: ___/____/____

Marital Status: _____ Relationship to Patient: _____

Employment Status: _____ Employer: _____

Home Phone: _____ Work: _____ Mobile: _____

Email: _____

Insurance Company: _____

Insurance Company Address: _____ City: _____ State: ___ Zip: _____

Subscribers I.D.#: _____ Group #:_____

Insurance Company Phone Number: _____

(**Please provide your ID card with this information**)

Parent / Guardian Information

Parent / Guardian #2:

Relationship to Patient: _____

Name:_____ Middle: _____ Last:_____ Suffix:_____

Address: _____City: _____ State: _____ Zip: _____

SSN: _____-_____-_____ Sex: M / F DOB: ___/____/____

Marital Status: _____

Home Phone: _____ Work: _____ Mobile: _____

Emergency Contact

Relationship to Patient: _____

Name:_____ Last:_____

Home Phone: _____ Mobile: _____

Dependents

Name	Relationship to child	Birth date	Health problems

Insurance Authorization and Release

I hereby authorize New Jersey Pediatric and Adolescent Care, LLC to act on my behalf and submit charges to my insurance carrier. I authorize that any payment for these services be made directly to New Jersey Pediatric and Adolescent Care, LLC. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I also authorize New Jersey Pediatric and Adolescent Care, LLC to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____