**PASSAIC PEDIATRICS P.A.**
**Patient Information Registration Form**

**Patient's Full Name:…….…. Age:…… Sex: M F**
**D.O.B: ……. Address: ……..**
**City: ……. Zip Code: ……..…. Home Phone: ……**
**Cell Phone: ……. Email:…….**

**Mother's Name: ……..... Mother's Cell Phone: …..……**

**Mother's Address: …….. Mother's Occupation: ……..……**

**Mother's Employer Address: ……..…… Phone Number: ...……..**

**Father's Name: …….. Father's Cell Phone: ……**

**Father's Address: …… Father's Occuaption: ……**

**Father's Employer Address: ……. Phone Number: …..…….**

**Emergency Contact #1:…….**

**Relantionship: ……. Phone Number: ……**

**Emergency Contact #2: ……..**

**Relationship: ……. Phone Number: ……..**

**REFERRAL INFORMATION:**

**How did you know about us? ……**

**Insurance Information**

**Name of Primary Coverage:……..**
**Group #.....**
**ID#.....**
**Effective Date:……..**
**Card Holder Name:……**

**Name of Secundary Coverage:……..….**
**Group#.....**
**ID#.....**
**Effective Date:……**
**Card Holder Name: ……**

*Are you covered by Medicaid? YES NO Medicaid#..... Please give secretary a current Medicaid Eligibility Form. We ask all patients to show their insurance card or membership card so that we may make copies of them.*

PAYMENT AUTHORIZATION

**I……..….hereby authorize Passaic Pediatrics, PA to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him as a result of his claim. Although covered by insurance, I am aware that I am personally reponsable for all charges. A photo static copy of this authorization will be as valid as the original.**

**Signature: ……..…… Date: …….**