Pediatric & Adolescent Medical Center

160 Mountain Avenue, Suite 100
Hackettstown NJ 07840
Ph: (908) 852-8787; Fax 9088528187

Name (last)_____ (First) _____ (Middle Initial)___ S.S._____

Address _____
(Street) (City) (State) (Zip)

Birth date___ / ___ /_____ Age ___ Sex____ Home Phone _____

Cell Phone _____ Emergency / Alternate Phone _____

Responsible Party _____ S. S. # _____

Address if Different _____ Phone _____

_____

Primary Insurance Co. _____Policy _____Grp_____

Address _____

Name of Insured _____ Relationship to Insured _____

Birth date of Insured ___ / ___ / _____ Social Security # of Insured _____

Employer's Address of Insured _____

_____Work Ph _____

How did you find about us? _____

I certify that the above information is correct. I authorize treatment for the above named patient. I authorize payment of benefits to be made to Ped. & Adol.Med. C.

I understand that my personal Health Information will be protected by HIPPA regulations and I give permission to provide the minimum necessary information for my treatment, billing or health care operations. Initialed _____

I understand that it is my responsibility to bill my secondary insurance. I understand that I am financially responsible for any balance not covered by insurance. I accept the following terms and conditions:

- A fee of $30 will be due on returned checks for any reason
- After 90 days of office visits, a fee of 1.5% per month will be charged on unpaid balances
- I will be responsible for any collection costs involved, if it becomes necessary.

Signature: Parent / Guardian _____ Relationship _____ Date _____

(Payment is due at the time of visit)

Medical History (Please turn over) — continued next page

Medical History:

Ethnicity: Hispanic / Non Hispanic /Latino /Other / Unknown /Declined

Race: American Indian /Asian /African American /white /Other
Native Hawaiian /Pacific Islander / Unknown /Other

Smoking status: Smoker / Nonsmoker / Not applicable

Allergies: Food_____ Meds _____

Past History of: **Surgeries:** _____
_____

Medical Problems

1. _____
2. _____
3. _____

List Medications, if any being taken: _____
_____
_____

Birth History:

Full Term/Premature _____Wks Birth weight _____Lbs
Normal delivery/C-section _____

Social and Family History:

Mother's Name _____ Age_____
Father's Name _____Age _____

Marital status: married/divorced/separated/not married
Pets: None or dog/cat/hamster/turtle/birds

Siblings: Name Age Sex: M/F
_____
_____
_____
_____
_____

Significant Family History: (Please List if Any)

_____
_____
_____

Reason of today's visit

_____
_____