ACCOUNT NUMBER

INTEGRATED PEDIATRICS

666 Plainsboro Road, Suite 424, Plainsboro NJ 08536

PATIENT INFORMATION

PATIENT'S NAME-LAST	FIRST	MIDDLE	SEX	DATE OF BIRTH
PATIENT HOME ADDRESS, CITY, STATE, ZIP				
SIBLING'S NAMES AND AGES (EX : JACK, 9; AMY, 11…)				
PRIMARY FAMILY PHONE	PRIMARY FAMILY EMAIL			

FAMILY INFORMATION

FATHER'S NAME-LAST	FIRST	MIDDLE	EMPLOYER	
HOME ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	DATE OF BIRTH	SOC. SEC. #	
MOTHER'S NAME-LAST	FIRST	MIDDLE	EMPLOYER	
HOME ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	DATE OF BIRTH	SOC. SEC. #	

INSURANCE INFORMATION

INSURANCE COMPANY NAME:		
SUBSCRIBER'S NAME	POLICY NUMBER	GROUP NUMBER

AGREEMENT

1. I have received the HIPAA Notice of Privacy Practices

2. In the event of an Emergency, I authorize the staff of Integrated Pediatrics to contact the following persons for information and authorization of medical care:

Name	Relationship	Phone
Name	Relationship	Phone

3. I hereby authorize Integrated Pediatrics to furnish information to Insurance Carriers concerning my child's illness and treatments.

4. I, the undersigned, certify that I (or my dependent) have Insurance Coverage as mentioned above and assign directly to Integrated Pediatrics all Insurance benefits. I understand that I am financially responsible for all charges made for the services provided to my child, including the balance remianing after payment from Insurance benefits.

5. I hereby give my consent for use and disclose protected health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO).

6. With this consent Integrated Pediatrics may call, send mail/email to my address(es) and leave message(s) on voice mail or in person with reference to any items that assist the practice in carrying out TPO. This includes (but is not limited to) appointment reminders, insurance items and calls pertaining to my child's clinical care, laboratory results etc.

Signature of parent / legal guardian

Print Name

Date