PEDIATRIC PROFESSIONAL ASSOCIATES, P.A.

330 Ratzer Road Suite d-20
Wayne, NJ 07470

7 Oak Ridge Road
Newfoundland, NJ 07435

Phone 973-835-5556 Fax 973-628-7942

CHILDS NAME:	last_____ first_____ M / F
DATE OF BIRTH:	month_____ day_____ year_____
HOSPITAL:	
Primary Health Insurance: SOCIAL SECURITY NUMBER : mother_____father_____	
Emergency contact other than parent: name_____	phone_____

Name of Child's MOTHER Maiden name_____ single married separated divorced widowed Address: Home Telephone Is the child at this address?	Name of Child's FATHER single married separated divorced widowed Address: Same ☐ Home Telephone : same ☐ Is the child at this address?
Employer: **Work Telephone:** EXT: **Cell Phone:**	**Employer:** **Work Telephone:** EXT: **Cell Phone:**
If you are re-married, insert the name of the biologic parent:	

By signing below I agree that the information I have supplied is true and accurate to the best of my knowledge.

I authorize the release of information necessary to process any claims.

I authorize payment to be made directly to the provider of service and I will be responsible for payment of any denied claims or balance due as stated by the insurance carrier.

I am aware that payment on my account is ultimately my responsibility and not the insurance carrier's. I agree that if any payment balance is 30 days past due, a late fee of 1% per month will be added to my balance. If charges are sent to collection,

I agree to pay any expenses that Pediatric Professional Associate, P.A. incurs in collecting delinquent balances including court costs and a reasonable attorney's fees.

I acknowledge receiving a copy of the providers notice of privacy.

Mother's date of birth_____ Mother's signature_____

Father's date of birth _____ Father's signature _____