ROSELAND PEDIATRICS
PRACTICE LIMITED TO PEDIATRIC AND ADOLESCENT MEDICINE

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Patient Information

Patient's Name: _____ **Sex:** _____ **DOB:** _____
(Last, First)

_____ **Sex:** _____ **DOB:** _____

_____ **Sex:** _____ **DOB:** _____

_____ **Sex:** _____ **DOB:** _____

Address: _____
(STREET) **(CITY)**

_____
(STATE) **(ZIP CODE)**

Race: (Please Check)*optional*
- ☐ Caucasian
- ☐ African American
- ☐ Hispanic
- ☐ Asian

Other: _____

Ethnicity: (Please Check)*optional*
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Not Latino

Other: _____

Primary Language:

_____

Parent Information

Parent 1's Name: _____ **Parent 2's Name:** _____

Parent 1's DOB: _____ **Parent 2's DOB:** _____

Parent 1's SS#: _____ **Parent 2's SS#:** _____

Address: (If different from patient)

_____

_____

Address: (If different from patient)

_____

_____

Home Phone: _____ **Home Phone:** _____

Cell Phone: _____ **Cell Phone:** _____

Email: _____ **Email:** _____

Employer: _____ **Employer:** _____

Employer Phone: _____ **Employer Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Pharmacy Information

Name: _____ **Location:** _____ **Phone #:** _____

Insurance Information

Subscriber's Name: _____ **SS#:** _____ **DOB:** _____

Insurance Company: _____ **Phone #:** _____

Address: _____

ID #: _____ **Group #:** _____

Effective Date: _____

Health Saving Account Information

If you have a health saving account or High Deductible Plan, please provide a copy of your HSA card or a personal credit card that we may keep on file. By signing below, you agree to have your card billed for any non-covered services.

HSA Plan Name: _____ **Card #:** _____

Name on card: _____ **Effective Date:** _____

Expiration Date: _____

Signature: _____ **Date:** _____

I, _____, authorize *Roseland Pediatrics* to give my child reasonable and proper medical care by today's standards and release medical information for any kind of treatment or payment operations by the office staff of Roseland Pediatrics.

_____ _____

Signature of Parent or Legal Guardian **Date**

I acknowledge receipt of HIPPA (Health Insurance Portability and Accountability Act) Notice of Privacy Practices that became effective April 14, 2003.

_____ _____

Signature of Parent or Legal Guardian **Date**