

Pediatric Surgery Group, LLC
2130 Millburn Avenue, Maplewood NJ 07040

REGISTRATION FORM

(Please Print When Filling in This Form)

Today's date: / /	Referring Physician:
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PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Nickname:
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Birth date: ____/____/____	Age:	If Age is under 1 year: Birth Weight:	Patient's SS #:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street address:	Home # ()
	Cell #: ()

City:	State:	ZIP Code
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Who has legal custody of the child?	<input type="checkbox"/> Natural Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Grandparent <input type="checkbox"/> HRS <input type="checkbox"/> Adopted Parents <input type="checkbox"/> Other _____
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MOTHER'S INFORMATION

Name	Date of Birth: ____/____/____	Address if different from child:
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Employer	SS#	Phone #
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FATHER'S INFORMATION

Name	Date of Birth: ____/____/____	Address if different from child:
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Employer	SS#	Phone #
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PRIMARY INSURANCE INFORMATION

Name of Primary insurance:	Group #:	ID/Policy #:	Co-pay Amount:
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Subscriber's name:	Subscriber's S.S. #	Date of Birth: ____/____/____
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Address (if different from Patient):	Home # () -	Cell. #: () -
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Patient's relationship to Subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Other
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SECONDARY INSURANCE INFORMATION

Name of Secondary insurance:	Subscriber's name:	Group #:	ID/Policy #:
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Subscriber's name:	Subscriber's S.S. #	Date of Birth: ____/____/____
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Patient's relationship to Subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Other
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IN CASE OF EMERGENCY

Emergency Contact: - Name of local friend or relative (not living at same address):

Relationship to patient:

Home phone #:

Work phone #:

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The above information is true to the best of my knowledge.

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance

As required by the Privacy Regulations, I hereby acknowledge that I have reviewed a current copy of "[Notice of Privacy Policy](#)", revision date August 2006. I have read the Privacy Policy and understand my rights contained in the notice.

By way of my signature, I provide **Pediatric Surgery Group, LLC** with my authorization and consent to use and disclose my child's protected healthcare information for the purposes of treatment, payment and healthcare operations described in the Privacy Policy.

Patient/Guardian signature

Date

List any medical problems other than the current medical problem your child has:

1. _____
2. _____
3. _____

List all medications your child is taking or has taken in the last 5 years:

Does your child have any medication allergies? (If yes, please explain) ___ NO ___ YES

Does your child have any bleeding problems? ___ NO ___ YES

List all prior surgeries your child has had:

1. _____
2. _____
3. _____

Name of child's Pediatrician: _____ Address: _____

Telephone Number: _____

Are there any relatives who have the same or similar medical problems which your child currently has? (If yes, please explain) ___ NO ___ YES
