PRINT CLEARLY # TENAFLY PEDIATRICS, P.A.

Family's Last Name: _____ Date: _____

E-mail: _____ Patient Portal Registration (Y)(N) Refered by:_____

Pharmacy Name/Town: _____

PARENT INFORMATION:

■ MOTHER/GUARDIAN

First _____ Last _____ Maiden Name _____ Birthdate: _____

Address: _____ Social Security # _____ - _____ - _____

City: _____ State: _____ Zip Code_____

Phone 1: (_____) _____ Occupation: _____

Phone 2 : _____

Employer: _____ Employer Telephone: (____) _____

■ FATHER/GUARDIAN

First _____ Last _____ Social Security #: _____-_____-_____ Birthdate: _____

Address: _____

City: _____State: _____Zip Code_____

_____

Phone 1: (_____) _____ Occupation: _____

Phone 2: _____

Employer: _____ Employer Telephone: (____) _____

Name of Insurance: _____

Insured's Name: _____ ID#: _____ Group #: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Drivers License Number: _____

■ LIST ALL CHILDREN

Name (full name including middle initial)			**List Child's Health Problem**	**Birthdate**	**Race**
1)	M	F			
2)	M	F			
3)	M	F			
4)	M	F			
5)	M	F			
6)	M	F			
7)	M	F			

Do you permit us to share your child's immunizations with the state registry? YES/NO (circle)

Financial Agr eement

We will bill your insurance if we participate in your plan. If your insurance does not cover a service you will be responsible for the charge. Delinquent accounts will be submitted to a collection agency - any collection agency fees will be the parent's or guardian's responsibility. If we do not participate in your insurance, or you do not have insurance you must pay for your visit in advance. We must charge $30.00 for any returned check. We accept all major credit cards, checks and cash.

* HIPPA WAIVER*

I, _____, a patient, parent or legal guardian of children above have been informed that should I have questions regarding that Tenafly Pediatrics Privacy Policy or do not understand information in the Notice posted that I may direct these questions to the Privacy Officer.

_____ _____

Patient/Guardian Signature *Date*

OVER →

FAMILY HISTORY

Dear Parent: Please complete the following medical history. This information will assist us in caring for your family

MOTHER/GUARDIAN Age: _____ Pregnancies: # _____ Education:_____

Health Problems: _____

FATHER/GUARDIAN Age: _____ Pregnancies: # _____ Education:_____

Health Problems: _____

Is There Any Family History Of:	No	Yes	Relatives	Comments
ALLERGIES:				
Asthma				
Eczema				
Medications				
ANEMIA				
BLEEDING PROBLEMS				
KIDNEY DISEASE				
DIABETES				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
INTESTINAL PROBLEMS				
BONE PROBLEMS				
SCOLIOSIS				
ARTHRITIS				
NEUROLOGICAL PROBLEMS				
EMOTIONAL PROBLEMS				
LEARNING DIFFICULTIES				
INHERITED ILLNESSES				
DRUG/ALCOHOL PROBLEMS				

Is there any other information that you think will be helpful to us in the care of your children?: _____

_____

_____

_____