Monmouth Pediatric Group

MPG

An Affiliate of BCD Health Partners

PATIENT INFORMATION/DEMOGRAPHICS

Today's Date:_____

First Name:_____ Last Name:_____

Date of Birth:_____ ☐ Male ☐ Female

Patient's PCP (check one) ☐ Dr. Jordon ☐ Dr. Palidino ☐ Dr.Litsky ☐ Dr. Berghaus

Ethnicity : ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to Answer

Race: ☐ American Indian/AK Native ☐ Asian ☐ Black or African American

☐ Native HI/Pacific IS ☐ White ☐ Prefers not to Answer

The language I prefer to communicate in about my child's care is:

☐ English ☐ Spanish Other _____

*We ask this information as part of our Medical Home Model

PARENT / GUARDIAN DEMOGRAPHICS

Check all that apply ☐ Mom ☐ Dad Other:_____

Parent 1 First Name:_____ Last Name:_____ DOB:_____

Parent 2 First Name:_____ Last Name:_____DOB:_____

Guardian's First Name:_____ Last Name:_____DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Email Address:_____

Please list all phone numbers that apply: Home Phone:_____

Parent 1 Cell Phone:_____ Parent 1 Work Phone:_____

Parent 2 Cell Phone:_____ Parent 2 Work Phone:_____

Preferred number for evening reminder calls: ☐ Home ☐ Parent 1 Cell ☐ Parent 2 Cell

272 Broad Street | Red Bank, NJ | 07701
Phone: (732) 741-0456 | Fax: (732) 219-9477

GUARANTOR / INSURANCE INFORMATION

First Name: _____ Last Name: _____

Address: _____

_____

Phone #:_____ Date of Birth: _____

Patient's Relationship to Insured: ☐ Son ☐ Daughter Other: _____

Insurance Carrier Name: _____

Policy / ID Number:_____ Group Number: _____

Effective Date: _____ Employer: _____

EMERGENCY CONTACT : (in the event the parent(s) cannot be reached)

Contact Name: _____ Relationship:_____ Phone: _____

CONSENT

Consent to release:

I hereby authorize the physicians of this practice to release any and all medical information to the above name insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date if signing until it is revoked in writing. I have read this authorization and understand it.

Consent to assignment:

I hereby assign payment of medical services to this practice to which I am entitled or have incurred for medical and/or surgical expense relative to services rendered here. I understand I am financially responsible to said group for charges not covered by this assignment. I further agree in the event of non-payment to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

Consent to treat:

I authorize this practice to provide medical care to my child and authorize treatment of care in my absence if my child is accompanied by the following care giver (check all that apply:)

☐ Grandparent(s) / Sibling(s) Name(s): _____

☐ Nanny / Babysitter Name(s): _____

☐ Other _____ Name(s): _____

PLEASE NOTE: Unless accompanied by a note from a guardian, vaccinations will not be administered to minors.

Signature of Parent / Legal Guardian:_____

Date: _____