THE MEDICAL GROUP OF NEW JERSEY
HNR Pediatrics LLC, formerly:
Central Jersey Pediatric Group

Central Jersey Pediatrics
Infants, Children and Adolescents
www.cjpediatrics.com

Patient Information:

Name: _____ , _____ _____ **Sex: M** □ **F** □ **Date of Birth:**_____
(Last) (First) (Middle)

Address: _____

Home Phone # _____ **Cell #** _____ **E Mail** _____

Pharmacy # _____ **Referred By:** _____

Information about Mother:

Name: _____
Birth Date: _____
Social Security #:_____
Work Phone #: _____
Cell Phone #: _____

Information about Father:

Name: _____
Birth Date: _____
Social Security #:_____
Work Phone #: _____
Cell Phone #: _____

Parent's Marital status: Married □ Single □ Divorced □ Separated □ Widow □

Primary Ins. Name: _____
ID _____
Group # _____
Phone # _____

Secondary Ins. Name: _____
ID _____
Group # _____
Phone # _____

Statement from parents/Legal guardian/patient:

- **I/we understand that I am/we are financially responsible for all charges made for the services provided to my children, including the balance remaining after payment from insurance benefits.**
- **I/we authorize payments of insurance /medical benefits to pay directly to the doctor/doctor's group, otherwise payable to me.**
- **I/we hereby give my/our consent for use and disclose protected health information (PHI) about me/my child (children) to carry out treatment, payment and healthcare operations (TPO).**
- **I/we have received a copy of Central Jersey Pediatrics' Notice of Privacy Practices.**
- **With this consent, Central Jersey Pediatrics, may call, send mail or E-mail to my home or other alternative locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to me/my child's (childrens') clinical care, including laboratory results among others.**
- **I/we understand that it is my/our responsibility to update personal/financial/insurance information from time to time as necessary.**
- **I/We have read and understood terms and conditions of the office policies which are posted in the waiting room and on the website cjpediatrics.com.**

Mother's Signature: _____ **Print:** _____ **Date:** _____

Father's Signature: _____ **Print:** _____ **Date:** _____