REGISTRATION FORM

(PLEASE PRINT)

KidKare Medical P.A.
15-01 Brodway Avenue
Fair Lawn ,NJ 07410
Phone: 201-773 - 6171
Fax: 201- 773 - 4845

Date_____ Home Phone (_____) _____ Cell Phone (_____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID #_____

Address _____ E-mail _____

Sex _____ Age _____ Birthdate _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (___) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

PRIMARY INSURANCE

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

. _____ Phone (_____) _____

Occupation _____

Perrson Responsible Employed by _____ Business Phone (___) _____

Business Address_____

Insurance Company _____

Contract #_____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance?

Address (If different from patient's) _____ Phone (_____) _____

City_____ State _____ Zip _____

Subscriber Employed by_____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan_____

ASSIGNEMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
Name of Insurance Company(ies)
KidKare Meidcal all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.The above-named prcatice may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. Thisconsent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Date

_____ _____
Please Print name of Patient, Parent, Guardian of Representative Relation to Patient