Madison-Bernardsville Pediatrics LLC
8 Shunpike Rd.
Madison, NJ 07940

Bernardsville Pediatrics LLC
40 Morristown Rd. Suite 2D
Bernardsville, NJ 07924

REGISTRATION FORM

PATIENT (CHILD'S) INFORMATION

1. Last Name:_____ Middle Initial: __ First Name _____ Other Name: _____
   DOB: _____ Sex: ❑F ❑M Allergies: _____
2. Last Name:_____ Middle Initial: __ First Name _____ Other Name: _____
   DOB: _____ Sex: ❑F ❑M Allergies: _____
3. Last Name:_____ Middle Initial: __ First Name _____ Other Name: _____
   DOB: _____ Sex: ❑F ❑M Allergies: _____
4. Last Name:_____ Middle Initial: __ First Name _____ Other Name: _____
   DOB: _____ Sex: ❑F ❑M Allergies: _____

Ethnicity (data is used for statistical reporting)

❑Hispanic or Latino ❑Not Hispanic or Latino ❑Unknown ❑Other
❑Patient declined

Race (data is used for statistical reporting)

❑American Indian ❑Asian ❑African American ❑White ❑Other
❑Native Hawaiian/Pacific Islander ❑Undetermined ❑Patient declined

EMERGENCY CONTACT (preferably parents)

Preferred contact name: _____ Phone1: (___) _____ ❑Home ❑Work ❑Cell
Relationship to child: _____ Phone2: (___) _____ ❑Home ❑Work ❑Cell
Permission to leave voice mail: ❑Yes ❑No
Second contact name: _____ Phone1: (___) _____ ❑Home ❑Work ❑Cell
Relationship to child: _____ Phone2: (___) _____ ❑Home ❑Work ❑Cell

PHARMACY Name/Address: _____ Pharmacy phone: (___) _____

GUARANTOR INFORMATION (Guarantor is the person financially responsible for this patient's bill)

Guarantor: _____ DOB: _____ SS#: _____
Patient's Relationship to Guarantor:
Address: _____ City/State/Zip: _____
Home phone: (___) _____ Cell: (___) _____ Work: (___) _____
E-mail address: _____ OK to send reminders regarding your child: ❑Yes ❑No
Occupation: _____ Employer: _____ Employer address: _____

OTHER PARENT OR GUARDIAN

Parent or Guardian:

Patient's Relationship to Guardian:_____ DOB: _____ SS#: _____

Address: _____ City/State/Zip: _____

Home phone: (___) _____ Cell: (___) _____ Work: (___) _____

E-mail address: _____ OK to send reminders regarding your child: ❑Yes ❑No

Occupation: _____ Employer: _____ Employer address: _____

PRIMARY INSURANCE INFORMATION

Name of policy holder: _____ Relationship to child: _____

DOB: _____ Policy holder's employer: _____

Work phone: (___) _____ Insurance company: _____

Insurance company address: _____

Insurance company phone: (___) _____ Co pay: _____

Policy holder's ID #: _____ Policy holder's group #: _____

I have more than one active insurance plan ❑Yes ❑No (If 'Yes', please ask for an additional insurance form)

How did you hear about our practice? ❑Internet ❑Insurance Website ❑Word of Mouth ❑Postcard ❑Ad ❑Other _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Bernardsville Pediatrics LLC. I understand that I am financially responsible for any balance. I also authorize Bernardsville Pediatrics LLC or insurance company to release any information required to process my claims.

Parent/Guardian signature: _____ Date: _____