MILESTONES PEDIATRICS, LLC
11 EAST OAK STREET OAKLAND, NJ 07436 Phone: 201.485.7557 Fax: 201.485.7556

PLEASE PRINT ALL INFORMATION

Patient Data – List All Children in the Family that will be coming to the practice.

Last Name	First	M.I	Sex		D.O.B.	Name of Patient used in Hospital at Birth
			M	F		
			M	F		
			M	F		
			M	F		
			M	F		
			M	F		

ADDRESS _____APT # _____ HOME#_____

TOWN _____ STATE _____ ZIP _____

PARENT NAME _____ D.O.B. _____MALE or FEMALE

SOCIAL SECURITY #_____- _____ - _____ OCCUPATION _____
REQUIRED

EMPLOYER _____ PHONE (EXT) _____

EMAIL:_____CELL#_____

Please check box if you are allowing us to send unencrypted PHI via email. ☐

PARENT NAME _____ D.O.B. _____MALE or FEMALE

SOCIAL SECURITY #_____- _____ - _____ OCCUPATION _____
REQUIRED

EMPLOYER _____ PHONE (EXT) _____

EMAIL:_____CELL#_____

Please check box if you are allowing us to send unencrypted PHI via email.. ☐

(**ADDRESS IF DIFFERENT FROM PATIENT'S**) MOM / DAD (CIRCLE ONE)

ADDRESS _____APT # _____ TOWN_____STATE_____ZIP_____

PRIMARY INSURANCE COMPANY _____**ID #** _____**GROUP #** _____
SEE BOX BELOW FOR CLARIFICATION (REQUIRED)

SUBSCRIBER: 》Mom 》Dad 》Other_____**(Check One) Co-pay**_____

INSURANCE ADDRESS (REQUIRED): _____

_____**PHONE#**_____

SECONDARY INSURANCE COMPANY _____ **ID #** _____**GROUP #** _____
SEE BOX BELOW FOR CLARIFICATION (REQUIRED)

SUBSCRIBER: 》Mom 》Dad 》Other_____**(Check One) Co-pay**_____

INSURANCE ADDRESS (REQUIRED): _____

_____**PHONE#**_____

IMPORTANT Notice to Parent(s)/Guardian(s): In case the patient under our care is covered under two or more insurances, it is the parent's responsibility to provide Milestones Pediatrics with the correct primary insurance. For example,

- Parent with the first occurring date of birth is the primary subscriber for 'the patient"
- In case of doubt ask Milestones Pediatrics for clarification
- It is also the responsibility of the parent to supply Milestones Pediatrics with current insurance information should the information provided above

PHARMACY NAME _____ **ADDRESS** _____ **PHONE** _____

HOW DID YOU HEAR OF THE PRACTICE_____

PLEASE READ THE FOLLOWING NOTES AND SIGN YOUR CONCURRENCE BELOW. I "THE PARENT" OR "GUARDIAN" AGREES THAT:

1) ALL ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.
2) I AM RESPONSIBLE FOR PAYMENT, CO-INSURANCE PAYMENT, AND/OR COPAYMENT TO MILESTONES PEDIATRICS, LLC FOR THE SERVICES PROVIDED.
3) I WILL IMMEDIATELY INFORM MILESTONES PEDIATRICS, LLC OF ANY CHANGE OF ADDRESS, PHONE #, OR INSURANCE.
4) WHEN INSURANCE DOES NOT PAY FOR THE SERVICES RENDERED FOR REASONS SUCH AS DEDUCTIBLE NOT REACHED, INELIGIBILITY, TERMINATION OF POLICY, ETC., I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR SUCH SERVICES AND RELATED PAYMENTS,IT WILL BE MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFIT COVERAGE.

PRINT YOUR NAME _____DATE: _____

SIGNATURE _____