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		

PLEASE CIRCLE YOUR ANSWERS

HOME ADDRESS____________________________**APT#.**_________**CITY**_______________________________**STATE**_____**ZIP**_________

PARENT NAME___________________________________

D.O.B. ____/____/_________**MALE or FEMALE(CIRCLE)**

SOCIAL SECURITY #__________- __________ - ________

OCCUPATION ____________________________________

EMAIL:____

CELL#____

PARENT NAME ___________________________________ ____

D.O.B. _____/_______/_________**MALE or FEMALE (CIRCLE)**

SOCIAL SECURITY #__________- __________ -_____________

OCCUPATION ____

EMAIL:____

CELL#____

(

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

ADDRESS ____**APT #** ______ **CITY**______________________**STATE**__________**ZIP**______

1. Which origin do you closely identify yourself in – Hispanic, Latino or Spanish?
   1) Yes
   2) No
   3) Other (Please specify)
   4) Prefer not to say

2.How would you best describe yourself?
   1. American Indian or Alaska Native
   2. Asian
   3. Black or African American
   4. Native Hawaiian or Other Pacific Islander
   5. Other (Please specify)
   6. Prefer not to say

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 change.

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 ____