DELAWARE VALLEY PEDIATRIC ASSOCIATES, P.A.

132 FRANKLIN CORNER RD.
LAWRENCEVILLE, NJ 08648
P: 609-896-4141 F: 609-896-3940
www.delvalpeds.com

DIPLOMATES,
AMERICAN BOARD OF PEDIATRICS
GLENN S. PALSKY, MD, FAAP
EUGENE SHAPIRO, MD, FAAP
JULIE HALVORSEN, DO, FAAP
SANGEETA GAJERA, MD, FAAP
PRITI SHARMA, MD, FAAP

PEDIATRIC NURSE PRACTITIONERS
BETH LEAHY, MSN, CPNP
ANDREA PISCADLO, DNP, CPNP-PC
TRACY SHORE, MSN, CPNP

LACTATION SPECIALIST
DEBRA MANNELLA, RN, CBC

NEW PATIENT INFORMATION (PLEASE PRINT)

_____ _____ _____ Sex
(circle one) M F
PATIENT'S FULL NAME **DATE OF BIRTH** **AGE**

OTHER SIBLINGS: NAME_____ **DATE OF BIRTH**_____
NAME_____ **DATE OF BIRTH**_____
ETHNICITY: [ ] NOT HISPANIC OR LATINO [ ] HISPANIC OR LATINO [ ] PREFERS NOT TO ANSWER
RACE: [ ] NATIVE AMERICAN/ALASKA NATIVE [ ] ASIAN [ ] BLACK/AFRICAN AMERICAN [ ] NATIVE HAWAII/OTHER PACIFIC ISLANDER
[ ] WHITE [ ] OTHER _____ [ ] PREFERS NOT TO ANSWER
PREFERED LANGUAGE:_____

_____ _____ _____
PARENT'S FULL NAME **DATE OF BIRTH** **MARITAL STATUS**

_____
HOME ADDRESS [ ] PERMANENT [ ] TEMPORARY **CITY** **STATE** **ZIP**

_____ _____ _____
HOME PHONE # **WORK PHONE #** **CELL PHONE #**

_____ _____
EMAIL ADDRESS **SOCIAL SECURITY #**

_____ _____ _____
PARENT'S FULL NAME **DATE OF BIRTH** **MARITAL STATUS**

_____
HOME ADDRESS [ ] PERMANENT [ ] TEMPORARY **CITY** **STATE** **ZIP**

_____ _____ _____
HOME PHONE # **WORK PHONE #** **CELL PHONE #**

_____ _____
EMAIL ADDRESS **SOCIAL SECURITY #**

PREFERRED METHOD FOR APPOINTMENT REMINDERS: ******CHECK ONLY 1 PLEASE******

{ }TELEPHONE: ( )_____ **{ } TEXT: ( )** _____ **{ }**
EMAIL:_____

INSURANCE INFORMATION:

_____
PRIMARY INSURANCE COMPANY **SUBSCRIBER NAME** **ID#** **GROUP #**

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of medical benefits to DVPA for services rendered. I understand that I am financially responsible for any balances not covered by my insurance.
FINANCIAL POLICY (ATTACHED): I have read and understand the attached DVPA financial policies. I agree to keep DVPA accurately informed of my children's insurance status and to assign benefits to DVPA as necessary. As previously state, I agree that if it becomes necessary to forward my account to a collection agency, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50 % of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts, in addition to the original amount due.
PRIVACY POLICY: I have received a copy of the privacy notice of DVPA.

SIGN BELOW TO ACCEPT ALL OF THE POLICIES EXPLAINED ABOVE:

SIGNATURE:_____ **DATE:**
_____