DELAWARE VALLEY PEDIATRIC ASSOCIATES

132 Franklin Corner Rd. Lawrenceville, New Jersey 08648
ph: (609) 896-4141 | fx: (609) 896-3940 | contact@delvalpeds.com | www.delvalpeds.com

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 _____
(if necessary, list additional siblings on reverse side of this form)

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

Preferred Language_____

_____ _____ _____
Parent's Full Name Date of Birth Marital Status

_____
Home Address [ ]Permanent [ ]Temporary City State Zip

_____ _____ _____
Home Phone Number Work Phone Number Cell Phone Number

_____ _____
Email Address Social Security Number

_____
Employer Name and Address

_____ _____ _____
Parent''s Full Name Date of Birth Marital Status

_____
Home Address [ ]Permanent [ ]Temporary City State Zip

_____ _____ _____
Home Phone Number Work Phone Number Cell Phone Number

_____ _____
Email Address Social Security Number

_____
Employer Name and Address

Preferred Method of Contact for Appointment Confirmation (**CHECK ONLY ONE**):
[ ] Telephone Call:_____ [ ] Text:_____ [ ] Email:_____

INSURANCE INFORMATION:

_____
Primary Insurance Company Subscriber Name ID# Group Name/#

_____
Secondary Insurance Company Subscriber Name ID# Group Name/#

Assignment of Insurance Benefits: I hereby authorize direct payment of medical benefits to Delaware Valley Pediatric Associates 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 stated, I agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for a collection fee of 33.33% of the balance, in addition to the original amount due.

Privacy Policy: I have received a copy of the privacy notice of Delaware Valley Pedatric Associates, P.A.

Sign below to accept all of the policies explained above:

Signature: _____ Date: _____

All information forms must be completed and policies signed before your child is seen.