EDGEWATER PEDIATRICS, P.C.

115 River Road Suite 1003
Edgewater, NJ 07020
Dr. Sushma D. Kaul, M.D.

Welcome To Our Office! **New Patient Information** *Date:_____*

Patient's Name (Please Print)	*Date of Birth*	*Sex: M F*	*Religion(important)*
Street Address	*City and State*	*ZipCode*	*Home #*
Mother Name: *Father Name:* *Guardian Name:*	*Occupation (indicate if student)* *Mother:* *Father:* *Guardian:*	*Marital Status* *M S D W*	*Cell #* *Bus. Phone#*
Parent's Employer *Mother:* *Father:* *Guardian:*	*Employer's Street Address* *Mother:* *Father:* *Guardian:*	*City*	*State & ZipCode*
Mother SS#: *Father SS#:* *Guardian SS#:*	*Parent's Date of Birth* *Mother:* *Father:* *Guardian:*		*Language*

Person responsible for payment	*Street Address, City, State*	*ZipCode*	*Phone #*
Name of Insurance	*Insurance Address*	*Group #*	*ID #*
Secondary Insurance	*Insurance Address*	*Group #*	*ID #*
Emergency Contact 1 - Name	*Street Address, City, State*	*ZipCode*	*Phone #*

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been, made on advance with our office bookkeeper.

Insurance Authorization and Assignment:

Name of Policy Holder _____ I request that payment of authorized Medicare/ Other Insurance company benefits be made either to me or on my behalf
To Edgewater Pediatrics for any services furnished me by that party who accepts assignment/physician.
Regulations pertaining to Medicare assignment of benefits apply.
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim/ other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties or withholding this information).

Signature of Patient, Parent or Legal Guardian : _____

Who referred you to our clinic? (Please indicate name and phone number) _____

****All charges are due at the time of services****