HACKENSACK PEDIATRICS
MONA TANTAWI , MD, PC
177 SUMMIT AVENUE
HACKENSACK, NJ 07601
Tel: 201-487-8222; Fax: 201-487-2126

HACKENSACK PEDIATRICS
PEDIATRIC AND ADOLESCENT MEDICINE

PATIENT REGISTRATION

PATIENT INFORMATION

Today's Date: _____ (mm/dd/yyyy)

Patient Name: _____

Date of Birth: _____ (mm/dd/yyyy)

Address: _____

Gender: [ ] Male or [ ] Female

_____

City, State: _____

Referred By: _____
(i.e.: name of friend, doctor, or relative)

Zip Code: _____

CONTACT INFORMATION:

Mother's Name: _____

Father's Name: _____

Mother's Cell: _____

Father's Cell: _____

Mother's Home: _____

Father's Home: _____

Mother's Work: _____

Father's Work: _____

Mother's Email: _____

Father's Email: _____

Mother's Occupation: _____

Father's Occupation: _____

PHARMACY:

Name: _____

Street, City: _____

Phone: _____

Fax: _____

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PATIENT HISTORY

Patient Name: _____ Date of Birth: _____

Completed By: _____ Relationship: _____

(Please circle "Y" (yes) or "N" (no) or explain where required. Write N/A if not applicable)

Prior Pediatrician:

Last Dental Visit:

Last Eye Exam:

PREGNANCY & BIRTH

Mother's age at pregnancy?

Any illness during pregnancy? Y / N

Medications during pregnancy? Y / N

Smoking, alcohol, drugs during pregnancy? Y / N

Was baby early, late, or on time?

Type of delivery: Vaginal / C-Section

Birth weight:

Problems/Complications with baby at birth?

- Breathing: Y / N
- Jaundice: Y / N
- Other?

Any problems soon after birth? Nursery or home? What kind?

FAMILY MEDICAL HISTORY:

List all **blood** relatives of your child who have:
(F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

Asthma	Birth Defects
Allergies (Seasonal)	Sudden Infant Death
Allergies to Food	Early Deafness
Diabetes	Anemia/Blood Disorder
Epilepsy/Seizures	Mental Retardation
Heart Disease	Cancer
High Blood Pressure	Cystic Fibrosis
High Cholesterol	Arthritis
Tuberculosis	Muscular Dystrophy
HIV/AIDS	Drug Addition
Migraines/Headaches	Alcoholism

CHILD'S PAST MEDICAL HISTORY

Allergic Reactions to (if so, what kind)?

- Medicine: Y / N
- Food: Y / N
- Animals: Y / N
- Insect Bites: Y / N

Medications taken on regular basis? (excluding vitamins)

Immunizations up-to-date? Y / N

- Do you have a record? Y / N

Hospitalizations? When? Where? Why?

Serious Injuries? When? Where?

Whooping Cough: Y / N	Chicken Pox: Y / N
Rheumatic Fever: Y / N	Asthma: Y / N
Recurrent Infections?	Eczema: Y / N
- Ear Y / N	Seizures: Y / N
- Throat Y / N	Anemia: Y / N
Bleeding Tendency: Y / N	Hepatitis: Y / N
Problems with hearing: Y / N	Mumps: Y / N
Problems with vision: Y / N	

Other significant history:

DEVELOPMENT & BEHAVIOR

Age at which child:

- Sat alone
- Used sentences
- Walked
- Toilet Trained

Is Development normal for his/her age? Y / N

- How are grades in school?
- Problems in school? Y / N

Behavior problems? Y / N

FEEDING & NUTRITION

Colic or feeding problems during first 3 months? Y / N

Breast fed? Y / N

- Number of months:

Formula fed? Y / N

- Current brand:

Vitamins? Y / N Do the vitamins have Fluoride? Y / N

Special diet? Y / N

FAMILY PROFILE

Parents are:

- Married? Y / N
- Separated? Y / N
- Divorced? Y / N

Father's current age:

- Highest school grade:

Mother's current age:

- Highest school grade:

(List all brothers & sisters & their ages):

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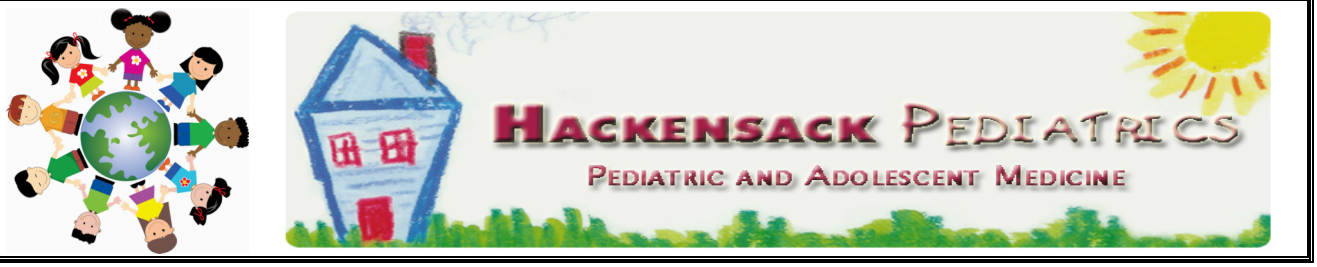

Patient/Child's Name _____ **Date of Birth:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Policy Holder Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Patient's ID#: _____ Patient's Group#: _____

Effective Date: _____ Today's Date: _____

SECONDARY INSURANCE:

Policy Holder Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Patient's ID#: _____ Patient's Group#: _____

Effective Date: _____ Today's Date: _____

Please list all children who currently are, or will be, patients at Hackensack Pediatrics

Name: (last, first MI)	Sex (M/F)	Date of Birth:	Same Insurance?
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N

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RESPONSIBLE PARTY (GUARANTOR)

Responsible party (Guarantor) is the individual who agrees to accept financial responsibility for the payment of all services performed at Hackensack Pediatrics. This individual may not necessarily be the insurance cardholder. Responsible Party must read and sign below.

Name _____ Relationship to Patient _____

Address _____

E-mail Address: _____ Occupation: _____

Social Security Number: _____ Phone (Home): _____

(Cell): _____ (Other Phone #): _____

I certify that the information I have reported with regards to my insurance coverage is correct. I authorize the release of any medical information necessary to process this claim and I permit a copy of this authorization to be used in place of the original. I also acknowledge that all charges are subject to a service charge of 1.5% per month after 60 days from date of service. Furthermore, I agree to pay any collection costs and legal fees incurred by this office with respect to these charges.

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to the PHYSICIANS at HACKENSACK PEDIATRICS for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

NAME: _____

SIGNATURE: _____ DATE: _____

CHILD ADVOCACY

As advocates for our young patients, Hackensack Pediatrics will not intervene in any custody disputes, or financial responsibility disputes, between parents or other responsible parties. The office will send statements to the address provided. However, we will not look to more than one party to fulfill financial responsibility.

NAME: _____

SIGNATURE: _____ DATE: _____

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HIPPA NOTICE OF PRIVACY PRACTICES

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Hackensack Pediatrics to release any medical or incidental information that may be necessary for either medical care, school forms, or in processing applications for financial benefit.

1) FULL DETAILS OF HIPPA POLICY ON DISPLAY IN OUR WAITING ROOM.
2) Signature below is acknowledgement that you have received this HIPPA Notice of Privacy Practices.
3) A photocopy of these assignments shall be valid as the original.

Patient/Child's Name: _____ **Date of Birth:** _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ **Today's Date:** _____

*** Nota de HIPPA de Practicas de Intimidad**

La firma debajo es solo reconocimiento que usted ha recibido esta Nota de nuestras Practicas de la Intimidad.

AUTHORIZED INDIVIDUALS

It is the law, and the policy of Hackensack Pediatrics, that you must authorize which family members and other individuals who may make appointments and accompany your child(ren) to their appointments. Therefore, the following individuals (other than parents) are authorized to act in your place with respect to any and all medical matters. Please note that as we have no control over these individuals, any private health information disclosed under this authorization is no longer protected by the Privacy Rule.

1) Name: _____ DOB: _____
Relationship to patient: _____ Phone#: _____

2) Name: _____ DOB: _____
Relationship to patient: _____ Phone#: _____

3) Name: _____ DOB: _____
Relationship to patient: _____ Phone#: _____

4) Name: _____ DOB: _____
Relationship to patient: _____ Phone#: _____

Patient/Child's Name: _____ **Date of Birth:** _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ **Today's Date:** _____