Passaic Pediatrics II

PATIENT REGISTRATION FORM

Today, s Date: _____

PATIENT INFORMATION: (Please use full legal name, no nickname)

Last Name: _____ First Name: _____ Middle Initials: _____

Sex (M) _____ (F) _____ Date of Birth: _____ Social Security #: _____

Home Phone #: (_____) _____--_____ Cell Phone #: (_____) _____--_____

Address: _____ City: _____ Zip Code: _____

Please tell us how you heard about us: _____ ***Referred by:*** _____

GUARANTOR INFORMATION:

Mother's Full Name: _____Date of Birth: _____ Social Security #: _____

Address: _____ City: _____ Zip Code: _____

Cell Phone #: (_____) _____--_____ Email: _____

Mother's Employer and Address: _____

Occupation_____ Employer Phone #: _____

Father's Full Name: _____Date of Birth: _____ Social Security #: _____

Address: _____ City: _____ Zip Code: _____

Cell Phone #: (_____) _____--_____ Email: _____

Father's Employer and Address: _____

Occupation_____ Employer Phone #: _____

PHARMACY INFORMATION:

Name: _____ Address: _____

Phone Number: (_____) _____--_____ Fax Number: (_____) _____--_____

913 Main Ave Passaic NJ, 07055
Ph (973) 458-8000 Fax (973) 458-8425

79 Market Street, Passaic NJ, 07055
Ph (862) 238-8333 Fax (862) 238-8338

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PATIENT REGISTRATION FORM

INSURANCE INFORMATION:

Primary Insurance: _____Insurance ID: _____

Are You covered by Medicaid? YES (____) NO (____) Medicaid #: _____

Please provide the secretary a current Medical Eligibility Insurance Card. We ask all patients to show their insurance cards, so that we can retain copies of it.

PAYMENT AUTHORIZATION

I _____hereby authorize _____ MD, to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the physician all benefits due to him because of his claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photocopy of his authorization will be valid as the original.

Signature _____ Date _____

We are required by law to ask the following questions, Thank You.

Today's Date: _____

Patient's Name: _____ Patient's Date of Birth: _____

What is the person's **RACE**? Please check one of the boxes below:

O White O Black or African American O Asian O Native Hawaiian or Pacific Islander O Native American O Unknow O Other

O I decline to answer

What is this person's **ETHNICITY**? Please check one of the boxes below:

O Hispanic or Latino O NOT Hispanic or Latino O Prefer NOT to say

O Unknown

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Medical Release Form

Passaic Pediatrics II PA

913 Main Ave, Passaic NJ 07055

Phone: (973) 458-8000, Fax: (973) 458-8425

Name of Prior Doctor or Hospital: _____

Phone # of Prior Doctor or Hospital: _____

Fax # of Prior Doctor or Hospital: _____

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

Patient Phone # : _____

** Parent Signature**: _____ Date : _____

PLEASE SEND US FOR THE FOLLOWING DATES OF SERVICE: _____

____ALL VACCINE RECORDS

____ALL GROWTH CHARTS

____ALL RADIOLOGY RESULTS

____ALL CONSULTATION NOTES

_____ALL LAB RESULTS

_____ALLPROGRESS NOTES

OTHER:_____

_____

Comment: _____

Confidential Notice

NEWBORN SCREEN RESULTS
MEDICAL RELEASE FORM
AUTORIZACION PARA DIVULGAR INFORMACION MEDICA

PASSAIC PEDIATRICS II
913 Main Ave. Passaic, NJ 07055
PHONE (973) 458-8000, FAX (973) 458-8425

TO: NEWBORN SCREENING PROGRAM

TELEFONO/PHONE: 609-530-8371

FAX: 609-530-8373

Mother's name/Nombre de la mama _____

Child's name/Nombre del Bebe: _____

Hospital where baby was born/Hospital donde nacio él bebe: _____

Child's DOB/Fecha de nacimiento del bebe: _____

Patient's Address/Dirección del paciente: _____

Patient's Phone#/Teléfono del paciente: _____

****FIRMA DEL PADRE/LA MADRE****: _____

PLEASE SEND US THE FOLLOWING: (*Por favor mandarnos lo siguiente:)*

☒ NEWBORN SCREEN RESULTS *(pruebas del recien nacido del hospital)*

Comments (*Comentarios*):

_____

*** Confidentiality Notice ***

The documentations accompanying this facsimile transmission contain confidential information belonging to the sender that are legally privileged. This information is intended only for the use of the individual or entity. Any other party is required to destroy the information after its stated need has been fulfilled, unless otherwise required by the state law. If you are not the intended recipient, you are hereby notified that disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately to arrange for return of these documents.

Passaic Pediatrics II

PATIENT REGISTRATION FORM

MEDICAL AUTHORIZATION FORM

I _____, being the parent and/ or guardian of _____ (hereinafter, my child(ren) do hereby authorize the following people:

1. _____
2. _____
3. _____
4. _____

To seek and obtain medical care for my child(ren) under this Authorization.

My child has the following allergies: _____

I agree to be financially responsible for the cost of any medical care provided to my child(ren) under this Authorization.

My health insurance carrier is _____ and my Policy Number is _____.

Signature of Parent (or legal guardian) _____ Date: _____

Witness Signature _____ Date: _____

I am responsible for following up with my child's: (read and check mark)

O Lab results

O Vaccines

O Specialist Consults

O Appointments

O General Evaluations

O Pick up filled forms

Legal parent or guardian's signature: _____

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Passaic Pediatrics II

Patient's Name: _____

PATIENT REGISTRATION FORM

Date: _____

PRIVACY NOTICE

Your Privacy Is Important

Passaic Pediatrics, PA. understands your privacy is important. You have received this notice in accordance with applicable state and federal laws and because you are a current or potential patient. This notice will help you understand what types of non-public personal information about you that is not publicity available.

We may collect, how we use it and how we protect your privacy.

Passaic Pediatrics, P.A. Privacy Policy Highlights

- We collect non-public personal information to process and administer our patient's business.
- We have policies and procedures in place to protect non-public personal information about our patients or their families.
- We do not sell non-public personal information about our patients or their families to third parties, i.e., companies or individuals that are not affiliated with us.
- We do not disclose any non-public personal information about our patients or their families to anyone, except as permitted by law.
- We disclose your private health information routinely to insurance companies, other providers, and others for purposes of treatment, payment, and healthcare operations.
- For all other purposes, we will either obtain your authorization or remove all information that could identify you as an individual.
- Our Privacy Policy applies to both current and former patients.

THIS PRIVACY NOTICE IS PROVIDED TO YOU FOR INFORMATIONAL PURPOSES ONLY. YOU DO NOT NEED TO CALL OR TAKE ANY ACTION IN RESPONSE TO THE NOTICE. WE RECOMMEND THAT YOU READ AND RETAIN THIS NOTICE FOR YOUR PERSONAL FILES.

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PATIENT REGISTRATION FORM

QUESTIONS ANS ANSWERS:

That detail Passaic Pediatrics II PA Privacy Policy

What Types of non-public personal information does Passaic Pediatrics II PA collect?

Passaic Pediatrics II PA employees, representatives, agents and selected third parties may collect non-public personal information about our patients or their families, including:

- Information provided to us, such as an application or other forms.
- Information about transactions with affiliates, a third party or us.
- Information from others, such as credit reporting agencies, employers, and federal state agencies.

The types of non-public personal information Passaic Pediatrics II P.A. collects vary according to the products or services provided and may include, for example: account balances, insurance premiums, marital status, and health history.

What does Passaic Pediatrics, P.A do to protect non-public personal information?

We restrict access to non-public personal information to those employees, agents, representatives or third parties who need to know the information to provide products and services to our patients or their families.

We have policies and procedures that give direction to our employees, agents and representatives acting on our behalf, regarding how to protect and use non-public personal information.

We maintain physical, electronic, and procedural safeguards to protect non-public personal information.

With whom does Passaic Pediatrics II P.A share non-public personal information, and why?

We do not share non-public personal information about our patients or their families with anyone, including other affiliated companies or third parties, except as permitted by law.

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PATIENT REGISTRATION FORM

We may disclose, as allowed by law, all types of non-public personal information we collect when needed to; affiliated companies, employees representatives and third parties that market our services, products and administer customer accounts on our behalf.

Examples of types of companies and individuals to whom we may disclose non-public personal information include attorneys, trustees, third-party administrators, insurance agents, insurance companies, insurance support organizations, credit reporting agencies, registered broker/ dealers, auditors, and regulators.

We do not share personally identifiable health information unless the customer or the applicable law authorizes further sharing.

Does Passaic Pediatrics II PA's Privacy policy apply to its agents and representatives?

Passaic Pediatrics II PA's Privacy Policy applies, to the extent required by law, to its agents and representatives when they are acting on behalf of Passaic Pediatrics, P.A.

Please note: There may be instances when these same agents and representatives may not be acting on behalf of Passaic Pediatrics, P.A. in which case they may collect non-public personal information on their own behalf of another. In these instances, Passaic Pediatrics, P.A's Privacy Policy would not apply.

Will Passaic Pediatrics, P.A.'s Policy Change?

Passaic Pediatrics II P.A. reserves the right to change any of its privacy policies and related procedures at any time, in accordance with applicable federal and state laws. You will receive appropriate notice if our Privacy Policy changes.

I hereby acknowledge that I have been presented with a copy of Passaic Pediatrics, P. A's Notice of Privacy Practices.

_____ _____

Signature of Parent/ Patient Date

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New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

IMM-32
DEC 22