NEW PATIENT REGISTRATION FORM
HILLS PEDIATRICS INC.
613 COURTYARD DR.
HILLSBOROUGH, NJ, 08844

LAST NAME_____ FIRST NAME_____ MIDDLE NAME_____

BIRTH DATE_____ SEX M F

STREET ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

PHONE _____ CELL PHONE_____ EMAIL_____

ID# (*office use only*) _____

PRIMARY POLICY CARD HOLDER INFORMATION

LAST NAME_____ FIRST NAME_____

BIRTH DATE_____ SEX M F

STREET ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

PHONE_____ EMAIL:_____

INSURANCE NAME _____

POLICY NUMBER_____ GROUP NUMBER_____

SECONDARY INSURANCE (Circle One) YES NO

NOTIFY IN CASE OF AN EMERGENCY

NAME_____ PHONE_____

I UNDERSTAND THAT PAYMENT FOR ALL MEDICAL CARE IS DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT IT IS MY RESPONSIBILTY TO PAY ANY DEDUCTIBLE, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COST INCURRED IN THE COLLECTION OF PATIENT'S ACCOUNT IN CASE OF DEFAULT. I HEREBY GRANT PERMISSION TO HILLS PEDIATRICS TO RELEASE ANY PERTINENT INFORMATION TO MY INSURANCE COMPANY UPON REQUEST, AND I ALSO AUTHORIZE PAYMENT DIRECTLY TO HILLS PEDIATRICS. A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNATURE_____ **DATE**_____

ACKNOWLEDGMENT OF NOTICE PRIVACY PRACTICE

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICE FOR:

PRINT PATIENT NAME_____

SIGNATURE_____

DATE_____

VIS (vaccine information statements) can be found at https://www.cdc.gov/vaccines
VIS vaccine information can be found in each of our exam rooms.
Free copies of VIS are available at the front desk.

INITIAL _____ **DATE** _____