FOREST PEDIATRICS, PA

Susan Kushner, MD FAAP
Melissa Garofalo Monaco, MD FAAP

299 Forest Avenue
Paramus, NJ 07652
Tel: (201)267-0888
Fax: (201)483-8874

New Patient Form

Patient Name (First, Middle Initial, Last) : _____

Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____ / _____ / _____ Gender: ____

For Office Use Only: Records Received: _____

Sibling Name:	Date of Birth:	Gender:

Insurance Company: _____

Primary Insured Name: _____

ID#: _____

I authorize Forest Pediatrics, PA to provide pertinent records to any insurance company.

X_____

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X_____

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Mothers Name : _____

Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____ / _____ / _____

Phone Number: _____ Email: _____

Employer Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone #: _____

Fathers Name : _____

Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____ / _____ / _____

Phone Number: _____ Email: _____

Employer Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone #: _____

Emergency Contact Other than Parents:

Name: _____ Phone Number: _____

Referring Physician: _____

How did you hear about us?: _____

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Thank you for choosing Forest Pediatrics, PA to provide your child with the highest quality care. The following is a statement of financial policy, which we require you to read and sign prior to initial treatment.

Patients with Insurance: All Co-Payments are payable at time of service. A $10.00 administrative charge will apply for non-payment on the day of service. There is a $50.00 fee for missed appointments unless cancelled with 24 hours notice.

Patients without Insurance: Full payment is due at time of service. We accept cash, checks, and credit/debit cards. We do not accept American Express. A $30.00 fee will be imposed for amy returned check/credit/ or debit card payments.

As a courtesy, we will bill your insurance carrier. If payment is not received within 60 days, the "Responsible Party" will be billed the outstanding balance. Please let us know in advance if you have any questions about our policy.

I acknowledge that I have been provided with the above information correctly and accept responsibility for any outstanding balance due.

Signature: _____ Date: _____