Colonia Office
795 Inman Ave
Colonia, NJ 07067
Ph: (732) 396-0700
Fax: (732) 396-0701

Plainfield Office
120 W 7th St. Ste 203
Plainfield, NJ 07060
Ph: (908) 757-8687
Fax: (908) 481-4891

Initial Patient Information

Name of person filling the form: _____ Date: _____

Relationship to Patient: _____

Patient information

Full name: _____
FIRST LAST MI

Address: _____

_____
CITY STATE ZIP

Sex: ☐ Male ☐ Female

Date of Birth: _____
MM/DD/YYYY

Demographics

Language(s) _____

Race/Ethnicity _____

Hispanic/Latino ☐ Yes ☐ No

Guarantor information

Relation: ☐ Mother ☐ Father ☐ Guardian

Full name: _____
FIRST LAST MI

Address: _____
STREET APT

_____
CITY STATE ZIP

Date of Birth: _____ **Email[1]:** _____

Employer: _____ (H) Phone: _____

(C) Phone: _____ (O) Phone: _____

[1] Your email address will be used to create your Patient Portal: a secure website that allows access to personal health information using a secure username and password.

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Initial Patient Information

Emergency Contact(s)

Name:		Name:	
Address (apt):		Address (apt):	
City/State/Zip:		City/State/Zip:	
Relationship to Patient:		Relationship to Patient:	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	

Primary Insurance / Secondary Insurance

Insurer:		Insurer:	
Insured's Name		Insured's Name	
Address Line 1:		Address Line 1:	
Address Line 2:		Address Line 2:	
Relationship to Patient:		Relationship to Patient:	
Effective Date:		Effective Date:	
Policy #		Policy #	
Group #		Group #	

Pharmacy Information

Name:			
Town:		Phone Number:	

Consent for Treatment / Release of Information / Assignment of Benefits

I consent to the treatment necessary for the care of the patient indicated on this form. Authorization is hereby granted to release information as may be necessary to process and complete my claim. I hereby authorize payment of medical benefits to be paid directly to the attending physician for services rendered.

Signature: _____ Date: _____

Consent for New Jersey Immunization Information System

I have received information about the NJIIS and understand that the purpose of this program is to help remind me when my child's immunizations are due and to keep a central record of 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 child's record from my primary health care provider, my local health department, or the New Jersey department of health (NJDOH).

Signature: _____ Date: _____