Colts Neck Pediatrics

Patient Information

Last Name: _____ ***First Name:*** _____

Sex: _____ ***Date of Birth:*** _____ ***Phone #:*** _____

Mother's Cell #: _____ ***Father's Cell #:*** _____

Address: _____ City: _____ Zip: _____

Father's Name: _____ Mother's Name: _____

Prior M.D. _____ Referred By: _____

Responsible Parties (Must Include All)

( ) Father ( ) Legal Guardian (Full Name): _____ DOB: _____

Address: _____ City: _____ Zip: _____

SSN: ___ ___ _____ Driver's License #: _____

Employer: _____

Employer Address: _____ City: _____ Zip: _____

Employer Phone #: _____

( ) Mother ( ) Legal Guardian (Full Name) _____ DOB: _____

Address: _____ City: _____ Zip: _____

SSN: ___ ___ _____ Driver's License #: _____

Employer: _____

Employer Address: _____ City: _____ Zip: _____

Employer Phone #: _____

Financial Policy

Thank you for choosing Colts Neck Pediatrics to provide your child with the finest quality care.
Please understand that payment of your bill is considered part of your child's treatment. 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 & DEDUCTIBLES MUST BE PAID IN FULL AT TIME OF SERVICE.**

Patients without Insurance: **FULL PAYMENT IS DUE AT TIME OF SERVICE.**

We accept cash, checks and credit cards. A $20 fee will be imposed for any returned checks/credit 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 regarding this policy.

I acknowledge that I have answered the above questions to the best of my ability. I also accept responsibility on any and all expressions incurred to enforce collection of amount due to Colts Neck Pediatrics.

Signature: _____ Date: _____

Siblings (1st Names):

1. _____
2. _____
3. _____

Problem List (for Doctor to write only):

1. _____
2. _____
3. _____

Allergies (Drug or Food):

1. _____
2. _____

Pharmacy Name & Phone #:

_____

_____