INTEGRAL CARE PEDIATRICS
Dr. Barry Prystowsky Dr. Maria Turizo
562 Kingsland Street, Nutley, NJ 07110
PATIENT REGISTRATION FORM **Date**_____

Patients' Last Name _____ **First Name** _____ **Middle Initial** ____

Patient's DOB ____ / _____ /_____ Social Security Number _____ - _____ -_____

Address_____ City_____ State _____ Zip _____

Parent/Guardian Name_____ **Relationship to Child** _____

Email Address _____

Home Address _____ City _____State _____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Second Parent/Guardian_____ **Relationship to Child** _____

Home Address _____City _____State _____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Emergency contact (not living with you) name _____**Relationship** _____

Phone Number_____ Address_____

Insurance Name _____**Phone Number** _____

Child's ID _____ **Group #** _____

Policy Holder Full Name_____ Policy Holder's DOB_____

Secondary Insurance_____ Group and ID#_____

I consent to the enrollment of my child in the New Jersey immunization information system: Yes/No

If someone other than the legal guardian will bring the child to the visit, **Integral Care Pediatrics** requires a written document signed by the legal guardian, authorizing that person to bring the patient and to have access to the health record, as well as valid ID of the person at the moment of the visit.

I acknowledge receipt of the Practice's Notice of Privacy Practices.

I, the undersigned give my authorization to treat and assign directly to **Integral Care Pediatrics, LLC**, all medical benefits, if any otherwise payable to me for services rendered. I understand that payment of all medical care is due at the time of service. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. In case of divorced parents, responsibility of payment shall be of the guardian bringing the child in for treatment. I understand that I am responsible for any costs incurred in the collection of patient's account in case of default, including reasonable attorney fees and court costs. I grant permission to **Integral Care Pediatrics, LLC** to release any pertinent information to my insurance company upon request. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

I authorize the use of this signature on all my insurance submissions. The information provided above is complete and accurate to the best of my knowledge. I will inform the office if any changes occur.

PARENT SIGNATURE_____ DATE_____