Roseland Pediatrics

Practice limited to pediatric and adolescent medicine

Jean P. Makhlouf, M.D., F.A.A.P.,PA
Tiziana Anello,M.D., F.A.A.P.,PA
Amanda Abou-Ezzi, M.D., F.A.A.P.
Stacey Tavel M.D., F.A.A.P.

556 Eagle Rock Avenue, Ste. 106
Roseland, NJ 07068
Telephone: 973.228.9190
Fax: 973.228.0730

Patient Information

Patient's Name: _____ **Sex:**_____**DOB:** _____
(Last, First)

_____ **Sex:**_____**DOB:** _____

_____ **Sex:**_____**DOB:** _____

_____ **Sex:**_____**DOB:** _____

Address:_____
(STREET) (CITY)

_____
(STATE) (ZIP CODE)

Race: (Please Check)* ***optional****

_____ Caucasian
_____ African American
_____ Hispanic
_____ Asian
Other: _____

Ethnicity: (Please Check)* ***optional****

_____ Hispanic/Latino
_____ Not Hispanic/Not Latino
Other: _____

Primary Language: _____

Parent Information

Parent 1's Name:_____
Parent 1's DOB:_____
Parent 1's SS#:_____
Address: (If different from patient)

_____

_____

Parent 2's Name: _____
Parent 2's DOB: _____
Parent 2's SS#: _____
Address: (If different from patient)

_____

_____

Home Phone:_____
Cell Phone:_____
Email:_____
Employer:_____
Employer Phone:_____

Home Phone: _____
Cell Phone: _____
Email: _____
Employer: _____
Employer Phone: _____

Emergency Contact:_____ **Relationship:**_____ **Phone#** _____

OVER→

Pharmacy Information

Name:_____ **Location:**_____ **Phone #:** _____

Insurance Information

Subscriber's Name:_____ **SS#:**_____ **DOB:** _____

Insurance Company:_____ **Phone #:** _____

Address: _____

ID #:_____ **Group #:** _____

Effective Date: _____

Health Saving Account Information

If you have a health saving account or High Deductible Plan, please provide a copy of your HSA card or a personal credit card that we may keep on file. By signing below, you agree to have your card billed for any non-covered services.

HSA Plan Name:_____ **Card #:** _____

Name on card:_____ **Effective Date:** _____

Expiration Date: _____

Signature:_____ **Date:** _____

I,_____**, authorize *Roseland Pediatrics* to give my child reasonable and proper medical care by today's standards and release medical information for any kind of treatment or payment operations by the office staff of Roseland Pediatrics.**

_____ _____

Signature of Parent or Legal Guardian **Date**

I acknowledge receipt of HIPPA (Health Insurance Portability and Accountability Act) Notice of Privacy Practices that became effective April 14, 2003.

_____ _____

Signature of Parent or Legal Guardian **Date**