

MEJIA PEDIATRICS LLC,

433 North Broad Street
Elizabeth, NJ 07208
Office (908) 436-1002
Fax (908) 436-1109



PATIENT INFORMATION

First Name: _____ Middle Name : _____ Last Name : _____

DOB: _____ *Social Security* _____ Sex: (circle one) F o M

Address: _____ Apt # / Floor: _____

City: _____ State: _____ Zip Code : _____

Telephones Home: _____ Cell: _____

PERSON RESPONSIBLE FOR THE INURANCE

First Name: _____ Middle Name : _____ Last Name : _____¹

DOB: _____ *Social Security* _____

Address: _____ Apt # / Floor: _____

City: _____ State: _____ Zip Code : _____

Telephones Home: _____ Cell: _____

INSURANCE INFORMATION

Insurance Company: _____ Member ID: _____

Group Number: _____ Effective Date _____

FAMILY INFORMATION

Relation patient to guarantor (Circle): Self; Son/Daughter; Adopted; Friend; Other _____

MOTHER/FATHER/ LEGAL GUARDIAN:

First Name: _____ Middle Name : _____ Last Name : _____

DOB: _____ *Social Security* _____

Address: _____ Apt # / Floor: _____

City: _____ State: _____ Zip Code : _____

Telephones Home: _____ Cell: _____

Hereby I (Mother/Father/Legal Guardian) authorize Mejia Pediatric LLC to provide services and treatments.
I have read and understood this patient history form and- certify that all of the information revealed is correct.

Signature: _____ Date: _____

Mejia Pediatrics LLC,

I (Father/Mother/Legal Guardian), _____;

authorize the following person listed below to bring my
child, _____ to the office visit at Mejia Pediatrics LLC .

I also understand that for the safety and well being of my child a photo ID will be
required of the person listed below.

Name:

Relationship:

Signature _____

Date _____

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