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:_____ A pt # / Floor:_____

City:_____State:_____ Zip Code :_____

Telephones Home:_____ Cell:_____

PERSON RESPONSIBLE FOR THE INURANCE

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

DOB:_____ *Social Security* _____

Address:_____ A pt # / 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:_____ A pt # / 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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