PEDIATRIC NEUROLOGY, PC

MAJA ILIC, M.D.

210 North Central Park Ave., suite 250 Hartsdale, NY 10530

P. 914-358-1162 F. 914-368-8343

REGISTRATION FORMS **PLEASE PRINT CLEARLY!**

Date:_____ **PATIENT'S DEMOGRAPHIC INFORMATION**

Patient's Gender **Male (OR) Female** **Status:** **Child/Single/Married/Widowed/Separated/Divorce**

Patient's Last Name: _____**First Name:**_____

Address: _____ **Apt:** _____

City:_____ **State:** _____ **Zip Code:**_____

Date of Birth: _____ **Age:**____ **Home #:** _____

Cell #: _____**Work #:** _____**Occupation:**_____

Parent's Name:_____**Parent's Contact #** _____

Emergency Contact Name:_____**Phone #:**_____**Relation:**_____

Primary Insurance: _____ **Insurance ID #:** _____

Pharmacy Name: _____ **Phone #:** _____

Pharmacy address: _____

How did you hear about us?_____

PRIMARY CARE PHYSICIAN INFORMATION

I also hereby consent to disclosed of my health information of the following purpose:

To provide diagnosis and treatment clinicals to my primary care physician for coordination of care.

_____ _____

Signature Date

Doctor's First and Last Name: _____

Address: _____

City:_____ State: _____ Zip: _____

Phone: _____ Fax: _____

NPI #_____Suite # _____

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AUTHORIZATION

Authorization for Release of Medical Information: I hereby authorize Pediatric Neurology to release any medical or incidental information that may, be necessary for medical care or to process medical insurance claims.

Signature: _____

Payment Policy: I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not cover by insurance including, without limitation, deductible, co-payments, co-insurance, or other amounts unpaid by my insurance, if benefits assigned. Pediatric Neurology P.C., files claims for Medicare assignment and only the managed care plans, which we are contracted. Claims will not be filed with other insurance carriers. If you plan to pay by check and it's dishonored a processing fee of $35 will be assessed.

Signature: _____

MEDICARE PATIENTS ONLY

I authorize the treating physician of Pediatric Neurology P.C. to release medical information about me to the Social Security Administration and Health Care Financing Administration (HCFA) or its intermediaries, or carriers, any information needed for this or related Medicare Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Pediatric Neurology P.C. pertaining to Medicare assignment of benefit applies.

Signature: _____

MOTOR VEHICLE

I certified that this is not related to a motor vehicle accident or work related accident.

Signature: _____

PERMISSION FOR TREATMENT

I, _____, hereby authorize Pediatric Neurology, P.C. , or its representatives, to provide medical services, such as; to conduct routine examinations, to perform diagnostic testing, to administer injections, and provide treatments. Which may also include all pharmaceutical products (medication) to myself or minor child (print name if applicable) _____ as maybe deemed necessary now and on subsequent visit.

Date: _____ **Signature**: _____

Relation to child (if applicable): _____

Patient - Child's Name_____**D.O.B.**_____

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IMPORTANT MEDICAL INFORMATION **PLEASE PRINT CLEARLY!**

Patient's Name:_____ **D.O.B.** _____

Height: _____ **ft** _____**in** **Weight:** _____**lbs** **Age:** _____

Patient's Past Medical History:

_____

Allergies: (NKDA) or _____

Patient's Surgical History:

_____

Mother History: _____

Father History: _____

Patient's Medication List and dosage:

_____

_____

_____

_____

Reason for Visit: _____

_____

_____

_____