Newark Pediatrics

FAMILY REGISTRATION

J. Bartley Stewart, Jr. M.D.
Sangita P. Modi, M.D.
Jason D. Walker, M.D.

Please PRINT and provide all information requested

PARENT RESP FOR BILL________________________________ TELEPHONE (___)____________________H

STREET ____ (___)____________________C

CITY______________________STATE_________ZIP___________

PARENT_________________________ EMPLOYER_________________________ PHONE__________________

PARENT_________________________ EMPLOYER_________________________ PHONE__________________

PRIMARY INSURANCE CO__________________________ I.D.#________________ Father ☐ Mother ☐

(For Delaware Policy Holders – your children's primary coverage is under the policy of the parent whose birthday falls the earliest in the calendar year)

Primary Insurers Date of Birth_____________ Secondary DOB_____________ Father ☐ Mother ☐

SECONDARY INSURANCE__________________________ I.D.#________________

CHILDREN NAMES:

Name_____________________________ DOB_____________
Primary Language: English ☐ Other ____________________
Race________________________ Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐

Name_____________________________ DOB_____________
Primary Language: English ☐ Other ____________________
Race________________________ Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐

Name_____________________________ DOB_____________
Primary Language: English ☐ Other ____________________
Race________________________ Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐

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Primary Language: English ☐ Other ____________________
Race________________________ Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Latino ☐

I hereby authorize Newark Pediatrics, PA to furnish information to insurance carriers concerning my dependent's illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance.

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Signature of Parent/Guardian Date