Vijaya Radhakrishna, M.D., F.A.A.P.
& Associates

155 Stelton Road
Piscataway, NJ 08854
Office: 732-752-8442
Fax: 732-752-3957

230 Rt. 18 N
East Brunswick, N.J. 08816
Office: 732-545-6005
Fax: 732-545-6009

PATIENT INFORMATION

Name of Child____________________ DOB ________ Sex: M F

Home Address______________________________
Street City State Zip

Mailing Address______________________________
Street City State Zip

Whom may we thank for referring you? ____________________

INSURANCE INFORMATION

Father/Guardian name____________________

Address (if different from patient's)____________________

____

Home Phone__________ Work Phone__________

Cell Phone____________________

Employer____________________

Employer's Address____________________

Social Security__________ DOB__________

Do you have insurance coverage for the patient? ______

Name of Insurance____________________

Insurance Address____________________

ID# __________ Group#__________

Is this insurance primary or secondary__________

Mother/Guardian name____________________

Address (if different from patient's)____________________

____

Home Phone__________ Work Phone__________

Cell Phone ____________________

Employer____________________
Employer's Address____________________

Social Security__________ DOB__________

Do you have insurance coverage for the patient? ______

Name of Insurance____________________

Insurance Address____________________

ID# __________ Group#__________

Is this insurance primary or secondary__________

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform the office of any changes in my child medical status.

I authorize payment of medical benefits to Dr. Vijaya Radhakrishna and for her to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I also authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Parent/Guardian ____________________ **Date** ____________________

CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION AND AUTHORIZATION

I____ the parent/guardian of the child named as ______________________________________ and related to me as _____________and this patient is covered under my health plan_____________________________ living at ___________________________ give this PEDIATRIC PRACTICE of Dr. Vijaya Radhakrishna, M.D. and her associates our consent to use and disclose any and all protected health information created by this practice and/or maintained in my child's "medical record" (defined to include all medical reports, diagnosis, clinical abstracts, case histories, proposed treatment, payment or health plans and prognosis, insurance information and/or any other information) as necessary to carry out treatment, payment or health care operations.

I, ____ the parent/guardian of the above noted patient here by authorize this pediatric practice of Dr. Vijaya Radhakrishna, M.D., and associates and whom so ever. Dr. Vijaya Radhakrishna may designate as her assistant(s) to perform diagnostic tests and to administer treatment, as he/she seems necessary to my child, whose name is ____.

AUTHORIZATION FOR PAYMENT

I, here by agree that I am financially responsible to this pediatric practice for all co pays, coinsurance, deductibles, and fees for non-covered services that are rendered to my child. To the best of my knowledge, I have furnished this pediatric practice all accurate information regarding my family health insurance including my child's health insurance. If any inaccuracies should occur, which will result in non-payment, I will be responsible for full payment of all services rendered.

Signature of Parents/Guardian of patient ____ Date ______________

I the parent/guardian of the above noted patient understand that this pediatric practice may refuse to provide treatment to my child, if I do not execute this consent. I further understand that I have the right to request that the above noted pediatric practice restrict how my child's medical record is used or disclosed to carry out the treatment, payment, or health care operations. However this pediatric practice is not required to agree with my requested restrictions. If this pediatric practice agrees to my requested restriction such restrictions will be binding on this pediatrics practice.

I the parent/guardian of the above noted patient understand that the terms of this consent is governed by the Health Insurance Portability and Accountability act of 1996, and its implementing regulations (HIPPA). I understand that I have the right to revoke this consent at any time except to the extent that this pediatric practice has taken action in reliance, therefore, I understand that any revocation must include the patient name, my name, address, telephone number, date of this consent and my signature and that I should send it to the HIPPA privacy Officer at:

Dr. Vijaya Radhakrishna and Associates

155 Stelton Rd
Piscataway, N.J. 08854

230 RT 18 North
East Brunswick, N. J. 08816

VIJAYA RADHAKRISHNA, M. D., F. A. A. P.
&
ASSOCIATES

Name______________________________ Date First Seen_______________

Birth Date _______________ Sex: F M Race____________________

Hospital___________________ Obstetrician________________

BIRTH AND DEVELOPMENT

Term___________________ Delivery: ☐Vaginal ☐ C-Section)

Birth Wt____lbs____oz **Height** ____in Condition at Birth________________

Condition 1st Week____

FEEDING HISTORY

☐ Breast ☐ ______________Formula ☐ Breast &___________ Formula

FAMILY HISTORY

Allergies(√)

	Age	Health	Environmental/Food	Type Of Allergy
Mother				
Father				
Sibling				
Sibling				

Miscarriage: ☐ Yes ☐ No Tuberculosis: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No Other Disease:_________________

Mother's Blood Type __________

Baby's Blood Type ___________

Credit Card Authorization Release Form

Patient (s)
Name:____

I,______________________________, authorize Dr. Vijaya Radhakrishna & Associates to collect any payments required with the credit card account number identified below, which will be kept on file for future use.

____
Signature

____
Print Name

____
Date

VIJAYA RADHAKRISHNA, M. D., F. A. A. P.
&
ASSOCIATES

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Fax # 732-545-6009

Name of the patient (s):____________________

Date:__________________

To The Parents/Guardians of our Patients:

As per our Office Policy, we would like to keep you informed if your Insurance Co **denies** for any of the Procedure codes below. It is your **responsibility** as a patient to pay for that, it could be for any of the following:

- Physical Visit (Routine Well). (Maximum allowed Routine visit met)
- Hearing Test
- Mantoux
- Typhoid (Travel shot)
- Strep Test
- Nutritional Guidance

WE WILL BILL INSURANCE ADDITIONALLY FOR THE FOLLOWING

- Sick visit in Addition to **Scheduled Physical** (Routine) if you bring to Doctors attention for any sickness and if there is any co pay for sick that is due during the visit.

- Addition to **Scheduled Visits for Shots** where you request doctor to see your child for symptoms.

Sincerely,

Patient/Parent Signature

Dr. Radhakrishna, Vijaya, M.D, F.A.A.P & Associates

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