PARK PEDIATRICS

Takoma Park Location
7610 Carroll Avenue
Suite 400
Takoma Park, MD 20912
Tel: (301) 891-6141
Fax: (301) 891-6841

Gaithersburg Location
501 North Frederick Avenue
Suite 320
Gaithersburg, MD 20877
Tel: (240) 801-4903
Fax: (240) 801-4905

Greenbelt Location
7527 Greenway Center Drive
Suite 215
Greenbelt, MD 20770
Tel: (301) 232-3638
Fax: (240) 241-4837

Hospital Newborn Care Acknowledgement

Hospital (Circle one): HCH / WAH / PG/ SGAH
Admit Date: _____

Attending Provider: _____
Discharge Date: _____

Circumcision Date: _____
(If applicable)

Baby's Information

Newborn's FULL Name: _____
First Middle Last

Newborn's Date of Birth: ____ ____ /____ ____/____ ____ ____ ____
Month Day Year

Parent's Information

Mother's FULL Name: _____
First Middle Last

Phone Number: _____-_____-_____

Father's FULL Name : _____
First Middle Last

Phone Number: _____-_____-_____

I hereby acknowledge that I have received a copy of the Park Pediatrics billing requirements and instructions for the newborn care my child received after birth. I understand that it is my responsibility to contact the Park Pediatrics billing department with the most up-to-date and accurate insurance and demographic information for my child, ***within 30 days of the child's birth****. I understand that I am fully responsible for any charges incurred from the care of my child.*

_____ _____
Parent's Signature **Date:**