

# PATIENT INFORMATION

Name: \_\_\_\_\_ Acct #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Town: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: F\_\_ M\_\_ Date Of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Business Phone #: (\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Marital Status (Please Circle One): Single Married Widowed Divorced Partner

**Parent, Spouse, or Significant Other Information:**

Name: \_\_\_\_\_ Business Phone #: (\_\_\_\_) \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Who Referred You To Our Office? \_\_\_\_\_

~~~~~  
**Insurance Information:**

Primary Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_

**PLEASE BE ADVISED THAT THIS IS A GROUP PRACTICE AND YOU MAY BE SEEN BY ANY OF OUR PHYSICIANS DURING YOUR FOLLOW UP VISIT.**

~~~~~  
**Statement for Patient Authorization and/or Responsible Party**

I authorize the undersigned physicians to release any information in the course of my examination or treatment. I also authorize the release of information for payment and health care operation. I further authorize any benefits due to me for services rendered to be paid directly to the undersigned physicians. I understand that if the physician's fees do not meet with my insurance company's customary and reasonable fees, I will therefore be responsible for any balance after insurance payments. I also understand that payments/co-payments must be made today for services rendered.

Also, please be advised that the doctor may send your x-rays and/or slides to be reviewed by our radiology and/or pathology department at Saint Barnabas Medical Center. Should this occur, please be aware that you will be billed from said department which is separate from our office. I certify that the above information which has been provided is true and correct to the best of my knowledge. I will notify this office of any changes in my status or the above information.

Patient/Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_