RWJ PHYSICIAN ENTERPRISE

PATIENT INFORMATION

Name: _____ SSN: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip Code: ___

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred phone: _____ E-Mail: _____

Please select your preference for receiving appointment reminders: _____

Please select your preference for all other communication needs: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Primary Care Physician: _____ PCP Phone and/or Town: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

ACCOUNT INFORMATION

Who is responsible for your bill? Self _____ *If other, please complete information below.*

Guarantor Name: _____ Relationship: _____

Guarantor Address (*if different from above*): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: _____

INSURANCE INFORMATION

Please present your insurance cards and photo ID with this form. If no card, please complete information below.

Who is the subscriber for your insurance? _____ *If other, please complete information below*

Subscriber Name: _____ _____ Relationship: _____

Date of Birth: _____ Sex: _____ SSN: _____

I acknowledge that I will be considered a self-pay patient until insurance information is provided and verified.

_____

SIGNATURE: DATE:

ADDITIONAL INFORMATION

Whom may we thank for referring you to our office? _____ _____

Preferred Language: _____ Ethnicity: _____ Race: _____

Ethnicity options: Hispanic/Latino, Non-Hispanic/Non-Latino, Not reported, Declined

Race options: White, Black or African American, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, Multiple Races, Not reported, Declined

ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION

I certify that the information provided herein is correct and accurate and hereby authorized RWJ Physician Enterprise to submit claims to Medicare, Medigap, and commercial insurance payers on my behalf. I assign any payment and/or benefit from these payers for these services to RWJ Physician Enterprise. I further authorize the release of any medical records necessary for the adjudication and payment of claims or any authorizations for services or procedures rendered or to be rendered. I understand balances for deductibles, co-insurance, co-payments, and non-covered services are my financial responsibility. If any balances become delinquent and are referred for further collection activity, I may become liable for any cost of collection including collection fees, court fees, and legal fees.

_____

SIGNATURE: DATE: