



Account No.		Entered Date
Reg. By		Office Site
<input type="checkbox"/> New	<input type="checkbox"/> Change	Info. Change:

### Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: \_\_\_\_\_

#### Patient Information

Patient Last Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

First Name: \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  M  F

Other Name: \_\_\_\_\_

Race: (please choose one of the following):

Marital Status:  Single  Married  Widowed  
 Separated  Divorced  Other

American Indian or Alaska Native  Black or African American  
 Native Hawaiian/Pacific Islander  White  Asian  
 Patient Declined

Addr1: \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Addr2: \_\_\_\_\_

Patient Declined

City, State, Zip: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Preferred Method of Contact:  Alt Phone Number  Email

Alt Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Letter  Phone Call (Cell)  Phone Call (Home)

Home E-Mail: \_\_\_\_\_

Driver's License # (DL#) \_\_\_\_\_ State(ST) \_\_\_\_\_

Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Emp. Status:  Employed Full Time  Employed Part Time

Employer: \_\_\_\_\_

Unemployed  Disabled  Homemaker

Address: \_\_\_\_\_

Student  Active Military  Self-Employed  Other \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Language:  English  Spanish  Other \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

#### INSURANCE INFORMATION (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: \_\_\_\_\_

Telephone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_

ID/Cert #: \_\_\_\_\_

Group/Plan #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  M  F

Relationship to Patient: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

SECONDARY CARRIER: \_\_\_\_\_

Telephone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_

ID/Cert #: \_\_\_\_\_

Group/Plan #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  M  F

Relationship to Patient: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Primary Care Phys.: \_\_\_\_\_

Refer. Phys. (if different): \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, St., Zip: \_\_\_\_\_

City, St., Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Pharmacy Name, Address & Phone #: \_\_\_\_\_

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**Guarantor Information**

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Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor: \_\_\_\_\_ Patient's Relationship to Guarantor: \_\_\_\_\_

Addr1: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Addr2: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F

City, State, Zip: \_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Employer: \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Driver's License # (DL#) \_\_\_\_\_ State(ST) \_\_\_\_\_ Guarantor E-Mail: \_\_\_\_\_

Emerg. Cont.: \_\_\_\_\_ Patient's Relationship to Emerg. Cont.: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Alt Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

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How did you hear about our practice?  Billboard  Brochure  Health Fair  Health Plan  Internet  Mass Mailing

Newspaper/Magazine  Ongoing Care  Patient  Phone Book  Phys. Off/ER  Relative  Radio  TV  Word of Mouth  Other

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IDX Account #: \_\_\_\_\_

**Assignment of Benefits/Authorization/Notice of Collection Action**

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Advocare Payment Policy and Notice of Privacy Practices for more information)

**Use of Photograph**

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

**New Jersey Vaccine Registry (if applicable)**

Please be advised that our office submits confidential data of children and adult vaccinations to your States Immunization Registry per the Statewide Immunization Registry Act. The purpose of this program is to keep a central record of patient's immunization history.

**Signature Required**

The undersigned acknowledges that I have read and understand the above terms and conditions.

_____	X _____
Patient Name (Please Print)	Patient Signature
_____	_____
Guarantor/Parent/ Guardian completing this form (Please Print)	Date
X _____	_____
Guarantor/Parent/ Guardian Signature	Date

***Please complete this section if the patient is covered by Medicare***

**In order to comply with Medicare regulations, please answer the following questions:**

- |   |   |  |   |
|---|---|--|---|
| Are you or your spouse employed?                  | <input type="checkbox"/> Y <input type="checkbox"/> N | Has treatment been authorized by the V.A.?                     | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Do you or your spouse have other insurance?       | <input type="checkbox"/> Y <input type="checkbox"/> N | Are you covered under the Black Lung Program?                  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Are you disabled or have end stage renal disease? | <input type="checkbox"/> Y <input type="checkbox"/> N | Is there Medigap coverage secondary to Medicare?               | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Is illness/injury the result of an auto accident? | <input type="checkbox"/> Y <input type="checkbox"/> N | Is there insurance coverage primary to Medicare?               | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Did illness/injury occur at work?                 | <input type="checkbox"/> Y <input type="checkbox"/> N | Is there employer supplemental coverage secondary to Medicare? | <input type="checkbox"/> Y <input type="checkbox"/> N |

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____	X _____
Patient Name (Please Print)	Patient Signature
_____	_____
Guarantor/Parent/ Guardian completing this form (Please Print)	Date
X _____	_____
Guarantor/Parent/ Guardian Signature	Date