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Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ 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: _____

First Name: _____ MI _____

Other Name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Addr1: _____

Addr2: _____

City, State, Zip: _____

Preferred Method of Contact: ☐ Alt Phone Number ☐ Email ☐ Letter ☐ Phone Call (Cell) ☐ Phone Call (Home)

Driver's License # (DL#) _____ State(ST) _____

Emp. Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other _____

Language: ☐ English ☐ Spanish ☐ Other _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Race: (please choose one of the following):
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Asian
☐ Patient Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Home Phone: (_____) _____

Alt Phone: (_____) _____

Home E-Mail: _____

Cell Phone: (_____) _____

Employer: _____

Address: _____

City, State, Zip: _____

Work Phone: (_____) _____

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

PRIMARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

SECONDARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Subscriber's Employer: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Primary Care Phys.: _____

Address: _____

City, St., Zip: _____

Telephone #: _____

Refer. Phys. (if different): _____

Address: _____

City, St., Zip: _____

Telephone #: _____

Pharmacy Name, Address & Phone #: _____

Guarantor Information

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: (_____) _____

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 the NJIIS (New Jersey Immunization Information System) 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?	☐ Y ☐ N	Has treatment been authorized by the V.A.?	☐ Y ☐ N
Do you or your spouse have other insurance?	☐ Y ☐ N	Are you covered under the Black Lung Program?	☐ Y ☐ N
Are you disabled or have end stage renal disease?	☐ Y ☐ N	Is there Medigap coverage secondary to Medicare?	☐ Y ☐ N
Is illness/injury the result of an auto accident?	☐ Y ☐ N	Is there insurance coverage primary to Medicare?	☐ Y ☐ N
Did illness/injury occur at work?	☐ Y ☐ N	Is there employer supplemental coverage secondary to Medicare?	☐ Y ☐ 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