

New Providence Internal Medicine Associates

PATIENT REGISTRATION

All information must be completed. Please print clearly.

Copay amount:

\$ _____

PATIENT

Last Name _____ MI _____

First Name _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) ____ - ____ Sex : M F

Birth Date ____/____/____ Soc. Sec # ____ - ____ - ____

Cell phone (____) ____ - ____

Email address: _____

Status Single Married Separated Divorced Widowed

INSURED/POLICYHOLDER (Leave blank if same as patient.)

Last Name _____

First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) ____ - ____ Sex : M F

Birth Date ____/____/____ Soc. Sec # ____ - ____ - ____

Relationship of Patient to Insured Self Spouse Child

Patient Employment Full time Part time Employed since ____ / ____ Retired Not Employed Student

Patient Employed by _____ Address _____

City, State, Zip _____ Work Phone (____) ____ - ____ Occupation _____

Insurance Information

Insured / Policy Holder _____ Insured Employed By _____ Birth Date _____ 19 ____

Primary Insurance Co _____ Group # _____ ID# _____

Insurance Address _____ Effective Date _____

Secondary Insurance Co _____ Group # _____ ID# _____

Insured / Policy Holder _____ Insured Employed By _____ Birth Date _____ 19 ____

Insurance Address _____ Effective Date _____

Who can we thank for referring you? (for new patients only) Circle one: Insurance Yellow Pages Newspaper Ad

Friend/relative/other doctor: _____

EMERGENCY CONTACT:

Name: _____ Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____

Assignment and Release of Information

I request that payment of authorized benefits be made either to me or on my behalf to New Providence Internal Medicine Associates for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature of Patient or Legal Guardian: _____ Date ____ / ____ / ____

Financial Responsibility

This information is accurate and true to the best of my knowledge. I understand that if my insurance company denies the claim then I am responsible for payment for all services rendered.