PATIENT REGISTRATION FORM

Reason for today's visit: _____

Was this a result of a Motor Vehicle Accident? ❑ Yes ❑ No Date of Accident: _____

Was this a result of a Job Injury? ❑ Yes ❑ No Date of Injury: _____

Patient's Name: _____ Sex: ❑ Male ❑ Female

Date of birth: _____/_____/_____ SSN: _____-_____-_____

Current Street Address:_____ Apt#/Floor/Suite#:_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Best form of contact? ❑ Home ❑Cell E-Mail Address: _____

Preferred Pharmacy (name and street): _____

How did you hear about us? _____

Primary Care Provider:_____

Emergency Contact Info

Name: _____ Contact Phone: (_____) _____-_____

Relationship to patient: _____

For any patient under the age of 18, please fill out this section*:*

Responsible Party (of the patient) Name:

_____ Sex: ❑ Male ❑ Female

Current Street Address:_____ Apt#/Floor/Suite#:_____

Date of Birth: _____/_____/_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Primary Insurance

Insurance Company: _____

Policy #: _____Group # _____

Subscriber Name_____ DOB_____

Patient Relationship to Subscriber_____

Secondary Insurance

Insurance Company: _____

Policy #: _____ Group # _____

Subscriber Name_____ DOB_____

Patient Relationship to Subscriber_____

AUTHORIZATION AND RELEASE

Authorization for Treatment: I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent.

Authorization for use of e-mail/cell phone: I voluntarily consent to the use of my personal e-mail and/or cellular phone via voice or text to receive newsletters or notifications. This is NOT to be used for my private medical records or health information.

Assignment of Insurance Benefits: I authorize payment directly to DOCTORS' OFFICE OF NEW JERSEY for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance co pays, coinsurances, and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize DOCTORS' OFFICE OF NEW JERSEY to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer, and follow up purposes.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice of Privacy Practices of DOCTORS' OFFICE OF NEW JERSEY I understand that a copy of this agreement may be used with the same effectiveness as the original.

PATIENT SIGNATURE: _____ **DATE:** _____
PARENT/GUARDIAN SIGNATURE: _____ _____ **DATE:** _____

CONSENT FOR NOTIFICATION OF TEST RESULTS/MEDICAL INFORMATION

I give permission to DOCTORS' OFFICE OF NEW JERSEY to:

1. Follow- up phone calls or call backs in regards to care at Doctors' Office of New Jersey using this phone #: _____
2. Leave message on my answering machine: (**circle one**) Yes/No
3. Discuss my health information with the following people _____

PATIENT SIGNATURE: _____ **DATE:** _____