HUNTERDON HEALTHCARE PARTNERS

Insurance Cards Copied: ☐ **PATIENT REGISTRATION FORM** Account #:

Date: Co-Payment: $

Please PRINT AND complete ALL sections below

PATIENTS PERSONAL INFORMATION: Marital Status: Single Married Divorced Widowed Sex:

Male Female

Name: (last name) (first name) (initial)

Street Address:

Home Phone

City: State: Zip: Work Phone:

Social Security #: Birth Date: Employer Name:

Drivers License: (State & Number)

Part Time Full Time

Spouse's Name: Spouse's Work Phone:

Spouse's Social Security #

PATIENTS/RESPONSIBLE PARTY INFORMATION:

Responsible party: Date of Birth:

Relationship to Patient: Self Spouse Other Social Sec. #

Responsible party's home phone: Work Phone :

Address: City: State: Zip:

Employer's name: Your Occupation:

Spouse's Employer's Name: Spouse's work phone:

Address: City: State: Zip:

PATIENTS INSURANCE INFORMATION:

PRIMARY insurance company's name:

Insurance Address: City: State: Zip:

Name of Insured: Date of Birth Relationship to insured:

Insurance ID number: Group number:

SECONDARY insurance company name:

Insurance Address: City: State: Zip:

Name of Insured: Date of Birth Relationship to insured:

Insurance ID number: Group number:

Check if appropriate ☐ Medigap policy ☐ Retiree coverage

PATIENT'S REFERRAL INFORMATION:

Referred by: If referred by a friend, may we thank her or him? ○ Yes ○ No

Name(s) of other physician(s) who care for you:

EMERGENCY CONTACT:

Name: Relationship:

Address: City: State: Zip:

Phone number (home) Phone number (work)

Assignment of Benefits * Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made to and any assisting physicians, for services rendered. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be valid as the original.

Date: Your Signature: _____