

Glendale Primary Care REGISTRATION FORM

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Aetna	<input type="checkbox"/> Amerihealth	<input type="checkbox"/> Horizon	<input type="checkbox"/> Keystone	<input type="checkbox"/> BCBS of NJ	
<input type="checkbox"/> Independence BC	<input type="checkbox"/> Cigna	<input type="checkbox"/> Medicare	<input type="checkbox"/> Healthnet		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.				
Patient/Guardian signature			Date	

Consent for Outpatient Services

I consent to examination, routine testing and medical treatment, which my doctor believes is necessary. I understand medicine is not an exact science; no guarantees or promises have been made to me about my treatment. I accept that the services provided are given in the least restrictive setting and manner to meet my needs. If special procedures are needed, I will be asked by my doctor to give separate informed consent. I have the right to refuse any drugs, treatment or procedures. I understand that my doctor is not responsible for my personal belongings during my care. I have read and understand this consent for care and my questions have been answered. My signature means I agree to the above. I can ask for a copy of this form.

Patient/Authorized Party

Date

Print Name

Witness Name and Initials

Date

Assignment of Health Insurance Benefits and Agreement for Financial Responsibility

I authorize payment to my doctor of any health insurance benefits that are payable to me, including Medicare payments, Medigap payments, and/or payments under any Employer Self-Funded Medical Expense Reimbursement Plan as governed by the Employment Retirement Income Security Act (ERISA), and/or payments from private insurance companies. I certify that the information that gave my doctor to bill for payment is correct. I assign and transfer to my doctor the right to act in my place to bill and collect all payments that are payable to me under any private or government plan of health benefits and/or to sue any insurer or other responsible party to obtain these payments. These payments may not be more than the balance due my doctors and/or hospital and I understand that I have to pay my doctor for all charges not paid by my health insurance. This payment authorization, assignment of benefits and agreement for financial responsibility is also binding on my administrators, executors, heirs and successors. I have read this assignment of benefits; I understand this assignment of benefits, and my questions have been answered.

Patient / Authorized Party

Date

Witness Name and Initials

Date

Authorization to Release Information for Treatment, Payment or Operations

I understand my doctor is allowed to use and disclose my health information for treatment, payment, or operations and I understand this use is allowed by law. I understand that when my doctor uses and discloses my health information as described in this authorization, my doctor may disclose general information contained within my medical record. I understand that full disclosure of my HIV, drug and alcohol abuse, or mental health treatment record will not occur without my specific consent relating to these conditions. My signature below means that I have read this authorization and I understand this authorization to release my health information.

Patient / Authorized Party

Date

Witness Name and Initials

Date

Verbal Consent

If consent from the patient is verbal because of the patient's physical inability to sign this consent form, then please check this box and have a staff member sign as a witness above and a second witness sign here.

Second Witness' Name

Date

Glendale Primary Care

9A West Browning Rd
Bellmawr, NJ 08031

In order to establish optimal relationship with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of the office. **PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED.** We accept payment in the form of Cash and Visa/Mastercard/American Express/. Also, if your insurance requires you to obtain referrals you must fill out a referral request form. Referral requests may take 48 hours to process. Your signature below signifies your understanding and willingness to comply with these policies.

DATE _____

PATIENT
SIGNATURE _____