Patient Information

Legal First Name: _____ **MI:** _____ **Last Name:** _____

Maiden or Nickname: _____ **Date of Birth:** _____ **Social Security #:** _____

Address: _____ **Apt #:** _____

City, State, Zip: _____

Email Address: _____

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

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer Information

Employer Name: _____ **Occupation:** _____

Address: _____ **If student:** ☐ Full Time

City, State, Zip: _____ ☐ Part Time

Insurance Information

PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

Primary Insurance Name: _____ **Address:** _____

ID #: _____ **Group #:** _____

Subscriber: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

Name: _____ **Date of Birth:** _____

Address: _____

Social Security #: _____ **Employer:** _____

Secondary Insurance Name: _____ **Address:** _____

ID #: _____ **Group #:** _____

Subscriber: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

Name: _____ **Date of Birth:** _____

Address: _____

Social Security #: _____ **Employer:** _____

Emergency Contact Information

In case of an emergency, we may contact:

Name: _____ **Phone #:** _____

Relationship to patient: _____

Supplemental Information

Pharmacy Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Mail Away Plan Pharmacy: _____

Phone #: _____

Ethnic Group:

- ☐ Decline to state
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:

- ☐ Decline to state
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Middle Eastern
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other
- ☐ White or Caucasian

Preferred Language:

- ☐ American Sign Language
- ☐ Arabic
- ☐ Cantonese
- ☐ English
- ☐ Hebrew
- ☐ Japanese
- ☐ Korean
- ☐ Mandarin
- ☐ Russian
- ☐ Spanish

Primary Care Physician: _____ **Referred by:** _____

Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to Women's Comprehensive Healthcare of New Jersey, its successors and assigns, or any individual it may designate for services provided.

I further agree to pay all costs of collection, including attorney's fees associated with collection of any amount due to services rendered and performed, I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to Comprehensive Women's Healthcare of New Jersey, its successors and assigns and any individual it may designate for any balance not covered by insurance.

_____

Signature of Patient or Parent of Minor Date

Authorization for Medicare

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Women's Comprehensive Healthcare of New Jersey for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

Patient's Signature Date

Receipt of Notice of Privacy Practices Written Acknowledgement

I, _____, have received a copy of Women's Comprehensive Healthcare of New Jersey's Notice of Privacy Practices.

_____ _____

Signature of Patient Date