Patient Information Sheet ***BORDENTOWN FAMILY MEDICAL CENTER***

Date: _____

PATIENT INFORMATION
Patient Name: _____ H. Phone:( ) _____

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Sex: M F Marital Status: S M W D Sep Soc Sec No: _____

Employer: _____ W. Phone: ( )_____

Work Address: _____ City: _____ State: _____ Zip: _____

Pharmacy Name/Phone #_____Spouse/Partner:_____

Referred by: _____ Primary Care Physician:_____

Parent/Guardian: (person to be billed if patient is under age 18)
Name: _____ H. Phone _____

Address: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Soc Sec No: _____

Employer: _____ W. Phone: ( )_____

Work Address: _____ City: _____ State: _____ Zip: _____

*****MEDICAL INSURANCE INFORMATION*****
Primary Insurance Company: _____Group#: _____

Policy/ID#: _____ Patient Relationship to Subsc: _____

Subscriber's Name: _____Date of Birth: _____Soc Sec#: _____

Secondary Insurance Company: _____Group#: _____

Policy/ID#: _____ Patient Relationship to Subsc: _____

Subscriber's Name: _____Date of Birth: _____Soc Sec#: _____

Other Insurances? _____

Subscriber information:(if different from Patient or Parent/Guardian): __Primary __Secondary

Address: _____

City: _____ State: _____ ZIP: _____

Employer: _____ W. Phone: ( )_____

Work Address: _____ City: _____ State: _____ Zip: _____

In Case of Emergency, Contact: _____ Relationship: _____

PLEASE TURN OVER

Home Phone: ( )_____ Work Phone: ( )_____ Other: ( ) _____

Please read, sign, and date the following to allow us to bill your insurance company for your medical care:

I have completed this form and certify that I am the Patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services. I authorize the release of medical history, information, or records concerning my diagnosis and treatment by *Practice Name* required to substantiate or explain insurance claims filed, and I authorize payment directly to South Trenton Family Medicine and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing.

If I have Medicare coverage, I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Practice Name* for any services furnished to me by that physician or supplier. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

_____ _____
Signature of Patient or Authorized Person (Address/Relationship) DATE

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf to *Practice Name* for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to

_____
(Name of Medigap Insurer)
any information needed to determine these benefits payable for related services.

_____ _____
Signature of Patient or Authorized Person (Address/Relationship) DATE

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I have read and reviewed the attached, and there are no changes to the information provided.
(To be re-signed once a year)

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____