Central Jersey Internal Medicine Associates, PA

Demographic Form

ALL ITEMS MUST BE COMPLETED. PLEASE PRESENT YOUR INSURANCE CARDS AND DRIVER'S LICENSE TO THE FRONT DESK

LAST NAME	**FIRST NAME**	**MAIDEN NAME**	**BIRTH DATE** / /	**AGE**
MARITAL STATUS S M WID DIV SEP	**SOC. SECURITY #**	**DRIVER'S LICENSE**	**HOME TELEPHONE**	**CELL PHONE #**
ADDRESS		**CITY**	**STATE**	**ZIP**
YOUR EMPLOYER		**OCCUPATION**	**WORK PHONE**	
REFERRED BY	**EMERGENCY NAME & PHONE # OF FRIEND OR RELATIVE NOT LIVING WITH YOU**		**ARE YOU IN THE MILITARY?** YES NO	
ETHNICITY	**PRIMARY LANGUAGE**		**E-MAIL ADDRESS**	

PREFERRED CONTACT METHOD: (please circle one) HOME PHONE CELL PHONE E-MAIL

1) PRIMARY INSURANCE COMPANY NAME		**INSURANCE COMPANY ADDRESS**	
INSURANCE POLICY ID #		**INSURANCE GROUP #**	**IS INSURANCE THROUGH SUBSCRIBER'S EMPLOYER?** YES NO
NAME OF SUBSCIBER	**SUBSCRIBER SS#**	**SUBSCRIBER'S BIRTH DATE**	**RELATIONSHIP TO SUBSCRIBER:** SELF SPOUSE CHILD OTHER
SUBSCRIBER'S EMPLOYER		**EMPLOYER'S ADDRESS**	
2) SECONDARY INSURANCE COMPANY NAME		**INSURANCE COMPANY ADDRESS**	
INSURANCE POLICY ID #		**INSURANCE GROUP #**	**IS INSURANCE THROUGH SUBSCRIBER'S EMPLOYER?** YES NO
NAME OF SUBSCRIBER	**SUBSCRIBER SS#**	**SUBSCRIBER'S BIRTH DATE**	**RELATIONSHIP TO SUBSCRIBER:** SELF SPOUSE CHILD OTHER
SUBSCRIBER'S EMPLOYER		**EMPLOYER'S ADDRESS**	

Do you have an advance directive? _____ **YES** _____ **NO**

PATIENT CONFIDENTIALITY - IT IS OUR POLICY TO CALL YOU TO CONFRM YOUR SCHEDULED APPOINTMENT AND/OR PROCEDURE AND TO REPORT TEST RESULTS. DUE TO THE PRIVACY RULE, WE CAN ONLY RELEASE INFORMATION TO THOSE YOU LIST BELOW.

NAME	RELATIONSHIP	TELEPHONE #

MAY WE LEAVE AN EMAIL? _____ YES _____ NO
ARE WE ABLE TO LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? _____ YES _____ NO
ARE YOU ABLE TO RECEIVE CALLS AT YOUR PLACE OF BUSINESS? _____ YES _____ NO
IF YES, CAN WE STATE WHO AND WHERE WE ARE CALLING? _____ YES _____ NO
DO WE HAVE PERMISSION TO RELEASE HEALTH INFORMATIONTO OTHER PROVIDERS IN CHARGE OF YOUR HEALTHCARE? _____ YES _____ NO

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. THE PATIENT IS RESPONSIBLE FOR FURNISHING OUR OFFICE WITH ALL THE INFORMATION REQUESTED ABOVE. THE PATIENT IS ALSO RESPONSIBLE FOR FURNISHING ANY NECESSARY INSURANCE FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION OR OFFICE SURGICAL PROCEDURES.

INSURANCE AUTHORIZATION & ASSIGNMENT & PAYMENT RESPONSIBILITY – I HEREBY AUTHORIZE CENTRAL JERSEY INTERNAL MEDICINE TO FURNISH INFORMATION TO ANY AND ALL INSURANCE CARRIERS CONCERNING MY MEDICAL RECORDS AND TREATMENT. I HEREBY ASSIGN TO THE PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF AND MY DEPENDENTS. I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND ALL THE CHARGES INCURRED FROM THOSE SERVICES. ALTHOUGH I HAVE REQUESTED THE PRACTITIONER TO BILL MY INSURANCE COMPANY ON MY BEHALF, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE FOR ANY REASON. I WILL ALSO BE RESPONSIBLE FOR ANY CO-PAYS, CO-INSURANCE AMOUNTS AND DEDUCTIBLES. ANY PAYMENTS MADE DIRECTLY TO THE PATIENT AND OWING TO THE PHYSICIANS WILL BE REMITTED PAYABLE TO CENTRAL JERSEY INTERNAL MEDICINE. I AGREE THAT IF MY ACCOUNT IS REFERRED TO AN OUTSIDE AGENCY OR ATTORNEY FOR COLLECTION, I WILL BE RESPONSIBLE FOR AN ADDITIONAL COLLECTION FEE OF FIFTY DOLLARS ($50.00) OR 20% OF THE BALANCE OWED WHICHEVER AMOUNT IS GREATER.

_____ _____

Signature **Date**