Patient Information

Hunterdon Cardiovascular Associates

Last Name: _____ First Name: _____ M.I. _____

Address: _____ Apt. _____

City: _____ State: _____ Zip _____

Social Security #: _____ Birth Date: _____ Race: _____ Ethnicity: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Ext. _____

Marital Status: ❑ Single ❑ Married Email _____ Sex: ❑ Male ❑ Female

Insurance Information - Primary / Secondary / Other

*****Please Give Your Insurance Cards To The Receptionist*****

Is this office visit related to a workman's compensation case? ❑ Yes ❑ No Or Motor vehicle accident? ❑ Yes ❑ No

Do you have health Insurance? ❑ Yes ❑ No Copay ❑ Yes ❑ No Amount $ _____

Primary Insurance: _____ Secondary Insurance: _____

Address _____ Address _____

Policy No. _____ Policy No. _____

Group No. _____ Group No. _____

Please Indicate policy holder for primary Insurance
❑ Self ❑ Spouse

Copay ❑ Yes ❑ No Amount $ _____

Please Indicate policy holder for secondary Insurance
❑ Self ❑ Spouse

Copay ❑ Yes ❑ No Amount $ _____

Pharmacy Information

Pharmacy Name: _____ City: _____ State _____ Phone _____

Patient's Employer Information

Employer's Name: _____ Patient's Occupation: _____

Address: _____ City: _____ State: _____ Zip _____ Telephone # _____

Policy Holder Information (If other than Patient)

Name: _____ Birth Date: _____

SS#: _____ Employer: _____ Employer's Phone #: _____

Employer's Address: _____ State _____ Zip _____

Emergency Information

In case of an emergency, we may contact: _____

Phone: _____ Relationship to Patient: _____

Primary Care / Referring Physician Information

Your Primary Care Physician's Name: _____ Telephone # _____

Address: _____ Release information to PCP? ❑ Yes ❑ No

Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits, authorize and assign any payment of medical benefits to Hunterdon Cardiovascular Associates, it's successors and assigns, or any individual it may designate for services provided.

I hereby agree that I am financially responsible to Hunterdon Cardiovascular Associates, for all Copays, insurance, deductibles and fees for non covered services which are rendered to me.

_____

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 Hunterdon Cardiovascular Associates for services furnished to be by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medical Services and its agents any information needed to determine these benefits or the benefits payment for related services.

_____

Signature of Patient or Parent of Minor **Date**

Patient Information Form

Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and health care operations (as defined in the Notice). We may leave messages on your answering machine; we may call your place of employment to give you information about your visit; we may discuss your care with a caregiver who brings you to our office, or to relatives that have shown interest in your care; we may discuss your medications, blood work, tests results with you on the phone or at our nurses station; we may schedule appointments for follow-up visits or diagnostic tests while you are in our check out area. If this is understood and agreeable, please sign and date below.

_____

Signature of Patient or Parent of Minor **Date**