Primary Care Partners

Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: ______________

Patient Information

Patient Last Name: ______________

First Name: ______________ MI ______

Other Name: ______________

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

Addr1: ______________

Addr2: ______________

City, State, Zip: ______________

Preferred Method of Contact: ☐ Alt Phone Number ☐ Email ☐ Letter ☐ Phone Call (Cell) ☐ Phone Call (Home)

Driver's License # (DL#) ______________ State(ST) ______

Emp. Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other ______

Language: ☐ English ☐ Spanish ☐ Other ______________

Social Security Number: ______________

Date of Birth: ______________ Sex: ☐ M ☐ F

Race: (please choose one of the following):
☐ American Indian ☐ Asian ☐ African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
☐ Unknown ☐ Patient Refused

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Unknown ☐ Other ☐ Patient Refused

Home Phone: (______) ______________

Alt Phone: (______) ______________

Home E-Mail: ______________

Cell Phone: (______) ______________

Employer: ______________

Address: ______________

City, State, Zip: ______________

Work Phone: (______) ______________

INSURANCE INFORMATION (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRRIER: ______________

Address: ______________

Group/Plan #: __________ Effective Date: __________

Subscriber's DOB: ________ SSN: __________ Sex: ☐ M ☐ F

SECONDARY CARRIER: ______________

Address: ______________

Group/Plan #: __________ Effective Date: __________

Subscriber's DOB: ________ SSN: __________ Sex: ☐ M ☐ F

Telephone #: (______) ______________

ID/Cert #: ______________

Subscriber's Name: ______________

Relationship to Patient: ______________

Telephone #: (______) ______________

ID/Cert #: ______________

Subscriber's Name: ______________

Relationship to Patient: ______________

Primary Care Phys: ______________

Address: ______________

City, St., Zip: ______________

Telephone #: ______________

Refer. Phys. (if different): ______________

Address: ______________

City, St., Zip: ______________

Telephone #: ______________

Pharmacy Name, Address & Phone #: ______________

Guarantor Information

Please complete if guarantor is other than self. (Guarantor) is the person financially responsible for this patient's bill.)

Guarantor: ______________________

Patient's Relationship to Guarantor: ______________________

Addr1: ______________________

Social Security Number: ______________________

Addr2: ______________________

Date of Birth: ______________________ Sex: ☐ M ☐ F

City, State, Zip: ______________________

Home Phone: (_______) ______________________

Employer: ______________________

Cell Phone: (_______) ______________________

Address: ______________________

City, State, Zip: ______________________

Work Phone: (_______) ______________________

Driver's License # (DL#) ______________________ State(ST) _______

Guarantor E-Mail: ______________________

Emerg. Cont.: ______________________

Patient's Relationship to Emerg. Cont.: ______________________

Home Phone: (_______) ______________________

Alt Phone: (_______) ______________________

Cell Phone: (_______) ______________________

How did you hear about our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Mass Mailing ☐ Newspaper/Magazine ☐ Ongoing Care ☐ Patient ☐ Phone Book ☐ Phys. Off/ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other

Primary Care Partners

IDX Account #:____________

This section must be signed in order for Primary Care Partners to bill your insurance company

Assignment of Benefits/Authorization/Notice of Collection Action

I request payment of insurance benefits for all services rendered to me or to my child/children to be made on our behalf to Primary Care Partners. I authorize Primary Care Partners to release medical information to my insurance carrier and its entities to determine payment for services rendered. I further understand I am responsible to pay certain amounts due. These amounts may include annual deductibles, copayments, charges denied by my insurance company as not covered or not medically necessary. I am responsible for any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing.

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

New Jersey Vaccine Registry (if applicable)

Please be advised that our office submits information of your child's vaccinations to the NJIIS (New Jersey Immunization Information System). The purpose of this program is to keep a central record of your child's immunization history.

Signature Required

The undersigned certifies that each has read and understands the above terms and conditions.

Patient Name (Please Print) | X Patient Signature

Guarantor/Parent/ Guardian completing this form (Please Print) | Date

X Guarantor/Parent/ Guardian Signature | Date

Please complete the section below if the patient is covered by Medicare

Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Primary Care Partners and/or the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

- Are you or your spouse employed? ☐ Y ☐ N
- Do you or your spouse have other insurance? ☐ Y ☐ N
- Are you disabled or have end stage renal disease? ☐ Y ☐ N
- Is illness/injury the result of an auto accident? ☐ Y ☐ N
- Did illness/injury occur at work? ☐ Y ☐ N
- Has treatment been authorized by the V.A.? ☐ Y ☐ N
- Are you covered under the Black Lung Program? ☐ Y ☐ N
- Is there Medigap coverage secondary to Medicare? ☐ Y ☐ N
- Is there insurance coverage primary to Medicare? ☐ Y ☐ N
- Is there employer supplemental coverage secondary to Medicare? ☐ Y ☐ N

The undersigned certifies that each has read and understands the above terms and conditions.

Patient Name (Please Print) | X Patient Signature

Guarantor/Parent/ Guardian completing this form (Please Print) | Date

X Guarantor/Parent/ Guardian Signature | Date

Primary Care Partners

ACKNOWLEDGMENT FORM

I have received and acknowledge my responsibility to read the following documents.

- Primary Care Partners Practice Philosophy
- Primary Care Partners Payment Policy
- HIPAA Notice of Privacy Practices

These documents are available for download on our practice website or upon request.

Print Name of Patient ____ Date ____________

Email Address of Patient/Legal Representative ____

Cell Phone of Patient/Legal Representative (________) _____ - ____________________

Signature of Patient/Legal Representative ____