Hunterdon Health

PLEASE COMPLETE / UPDATE YOUR ACCOUNT INFORMATION… THANK YOU!

INFORMATION ON FILE:

PATIENT INFORMATION:		MRN:		PATIENT ID:	
LAST NAME:		FIRST NAME:		NICKNAME:	MIDDLE NAME:
SOCIAL SECURITY #:	DATE OF BIRTH:	GENDER:	PREFERRED PROVIDER:	PREFERRED PHARMACY (Name & City):	
STREET/ MAILING ADDRESS:			CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE: EXT:		CELL PHONE:	E-MAIL:	
RACE: ☐ White ☐ Black/ African American ☐ Asian ☐ Multiracial ☐ Prefer not to answer ☐ Other			ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to answer	PREFERRED LANGUAGE:	

CUSTODIAL PERSON WITH WHOM PATIENT LIVES (IF APPLICABLE):

LAST NAME:	FIRST NAME:	NICKNAME:	MIDDLE NAME:
SOCIAL SECURITY #:	DATE OF BIRTH:	GENDER:	RELATIONSHIP:

PRIMARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY:			COPAY:
GROUP NUMBER/ NAME:		POLICY/ IDENTIFICATION NUMBER:	
LAST NAME OF SUBSCRIBER (POLICY HOLDER):		FIRST NAME:	MIDDLE NAME:
SOCIAL SECURTY #:	DATE OF BIRTH:	GENDER:	RELATIONSHIP TO PATIENT:
STREET/ MAILING ADDRESS:		CITY:	STATE: ZIP:
HOME PHONE:		DAY PHONE:	CELL PHONE:

SECONDARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY:			COPAY:
GROUP NUMBER/ NAME:		POLICY/ IDENTIFICATION NUMBER:	
LAST NAME OF SUBSCRIBER (POLICY HOLDER):		FIRST NAME:	MIDDLE NAME:
SOCIAL SECURTY #:	DATE OF BIRTH:	GENDER:	RELATIONSHIP TO PATIENT:
STREET/ MAILING ADDRESS:		CITY:	STATE: ZIP:
HOME PHONE:		DAY PHONE:	CELL PHONE:

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APPOINTMENT INFORMATION:				
APPOINTMENT DATE:	APPOINTMENT TIME:	REASON FOR APPOINTMENT:		
PATIENT NAME:	DATE OF BIRTH:	AGE:	GENDER:	
HOME PHONE:	DAY PHONE:	PROVIDER:	MRN:	ID:

EMERGENCY CONTACT INFORMATION:		
NAME:	PHONE:	RELATIONSHIP TO PATIENT:

LVING WILL/ ADVANCE DIRECTIVES:			
DO YOU HAVE A LIVING WILL OF ADVANCED DIRECTIVE?		YES	NO
IF NO, WOULD YOU LIKE MORE INFORMATION ON ONE?		YES	NO
WE WOULD LIKE TO CONFIRM YOUR APPOINTMENTS, IS THIS ACCEPTABLE TO YOU?		YES	NO
IF YES, AT WHAT TELEPHONE NUMBER SHOULD WE CONFIRM YOUR APPOINTMENTS?		PHONE:	
THIS NUMBER IS YOUR?	WORK	HOME	OTHER
WHO SHOULD WE ASK FOR AT THIS NUMBER?		RELATIONSHIP TO PATIENT:	

REFFERAL INFORMATION:
WHO REFERRED YOU TO OUR OFFICE?

PATIENT BILL OF RIGHTS:	
I ACKNOWLEDGE RECEIPT OF THE HUNTERON HEALTHCARE SYSTEM'S PATIENT BILL OF RIGHTS.	INITIAL:

ASSIGNMENT/ RELEASE/ CONSENT/ TO TREAT	
Permission is hereby granted to healthcare providers within this practice for testing, examinations, treatment, and procedures as deemed necessary in the course of my care, Information about me necessary to substantiate my insurance claims may be released by this healthcare provider. I authorize payment directly to the provider's office of all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by my insurance rendered on my or my dependent's behalf. I also acknowledge receipt of Hunterdon Medical Center's Notice of Privacy Practices, and I further agree and approve of HMC's use and disclosure as described in such privacy practices, including for permitted treatment, payment and healthcare operations.	
SIGNATURE:	**DATE:**