# PATIENT INFORMATION

**NAME:**_____ **DOB:**_____/_____/_____

**ADDRESS:**_____ **SOC. SEC #**_____-_____-_____

**CITY:**_____ **STATE:**_____ **ZIP:**_____

**TEL #(home)**_____ **TEL #(cell)**_____

**TEL# (work)**_____ **YOUR EMAIL** _____

**SEX: ___M___F** **Ethnicity: Spanish/Hispanic Origin? Yes_____No____**

| **MARITAL STATUS:** Please √ | | **EMPLOYED STATUS**: Please √ | | **RACE:** Please √ | |
|---|---|---|---|---|---|
| **MARRIED** | | **FULL TIME** | | **WHITE** | |
| **NEVER MARRIED** | | **PART TIME** | | **AFRICAN AMERICAN** | |
| **WIDOWED** | | **RETIRED** | | **AMERICAN INDIAN/ ALASKA NATIVE** | |
| **DIVORCED** | | **SELF-EMPLOYED** | | **ASIAN** | |
| **LEGALLY SEPARATED** | | **ACTIVE MILITARY** | | **NATIVE HAWAIIAN/ PACIFIC ISLANDER** | |
| **DOMESTIC PARTNER** | | **NOT EMPLOYED** | | **OTHER:** | |
| **ANNULLED** | | **STUDENT:** | | **PATIENT DECLINED/ UNKNOWN** | |
| | | | | | |

**LANGUAGE: PRIMARY:** _____ **SECONDARY:** _____

**PHARMACY:**_____
**Name** **Address** **Phone #**

**Your PRIMARY CARE Physician:**

**Name** _____ **Group Name:** _____

**ADDRESS:**_____ **CITY:**_____**STATE:**_____

**Your REFERRING Physician:**

**Name** _____ **Group Name:** _____

**ADDRESS:**_____**CITY:**_____ **STATE:**_____

## MEDICAL INSURANCE INFORMATION

**Primary Insurance:**_____ **ID#**_____ **Group#**_____

**Policy Holder :**_____ **Pol. Holder SS#**_____-_____-_____ **& DOB:**_____/_____/_____

**Second Insurance:**_____ **ID#**_____ **Group#**_____

**Policy Holder :**_____ **Pol Holder SS#**_____-_____-_____ **& DOB:**_____/_____/_____

# PATIENT INFORMATION

**Employer : _____ Occupation: _____**

**Address: _____ City _____ State ____ Zip _____**

**Is this a Work Related Injury: Yes_____ No_____ Date of Injury:_____**

**Description of Injury_____**

**Workman's Comp Info:_____**

**Claim #:_____**

**Our office is**

**Affiliated with:** The Valley Hospital, 223 N. Van Dien Ave., Ridgewood, NJ 07450
Surgicare Surgical Associates, 1124 E. Ridgewood Ave., Ridgewood, NJ 07450
HUMC at Pascack Valley, 250 Old Hook Road, Westwood, NJ 07675

**In network with:** Medicare and CIGNA-for Valley Hospital employees.

**Out of network with:** All insurance carriers other than above. You will be using your out-of-network benefits when scheduling appointments/surgery with our office. Upon request, we will provide you with the expected CPT code(s) and the associated fee(s). Please be aware that unforeseen medical circumstances may arise that cannot be disclosed up front. Your financial responsibility will be subject to co-payment, deductible and/or coinsurance as stipulated by your insurance plan and there is a possibility you will be responsible for costs in excess of those allowed by your health benefit plan. **You should contact your insurance carrier for more information about the costs for the services. Your insurance company is required to have a telephone hotline, an internet website, and an Insurance Plan Summary to help you understand the details of your policy which is to be designed to be clearly understood by the consumer.**

**Responsible to:** Provide the name practice name, mailing address, and telephone number of any other physician, such as an assistant surgeon, who services we arrange for you at the time a non-emergent service is scheduled. This information will be given to you when scheduling your procedure. This also includes anesthesiology, laboratory, pathology, and radiology that may be required for your care.

You will be asked to electronically sign our patient authorization policy regarding Authorization to Release Information and Assignment of Insurance Benefits which you will receive a copy of for your records.

Your signature below indicates that you have been made aware of all disclosures required by our office to be in compliance with the NJ Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act.

Patient Name (Printed): _____Date of Birth: _____

Patient Signature: _____Date: _____

Signature of Parent/Guardian _____Date: _____