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:	ETHNICITY:	PREFERRED LANGUAGE:
☐ White ☐ Black/African American ☐ Asian ☐ Other ☐ Multiracial ☐ Prefer not to answer	☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to answer	

CUSTODIAL PERSON WITH WHOM PATIENT LIVES (IF APPLICABLE):

LAST NAME:	FIRST NAME:	NICKNAME:	MIDDLE NAME:

SOCIAL SECURITY NUMBER:	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 SECURITY NUMBER:	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 SECURITY NUMBER:	DATE OF BIRTH:	GENDER:	RELATIONSHIP TO PATIENT:

STREET/MAILING ADDRESS:	CITY:	STATE:	ZIP:

HOME PHONE:	DAY PHONE:	CELL PHONE:

In case of EMERGENCY, please contact:

NAME: _____

PHONE: _____ RELATIONSHIP: _____

Do you have a Living Will or Advanced Directive? YES NO

If no, would you like more information on one? YES NO

Who referred you to our office?: _____

I acknowledge receipt of the Hunterdon 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.

If my physician or a member of the healthcare staff is exposed to one of my bodily fluids during the course of my treatment in the facility, I consent to the testing of my blood for the Human Immunodeficiency Virus (HIV) and Hepatitis B and C. The test results will be shared with the Hunterdon Medical Center Occupational Health physician, appropriate healthcare workers and the affected physician or employee, and the test results will be reported to public health agencies if and as required by law. I understand that additional information and counseling regarding this test are available to me at this time, and in the event such exposure event should occur.

_____

SIGNATURE DATE