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|  | C:\Users\BDillo01\OneDrive - AHS\6 AHP Files\AHP-AHS_B_CMYK_300.jpg | **Marc Mandel, M.D., F.A.C.S.**11 Overlook Road, Suite 160Summit, NJ 07901 |

 **Adult Registration Form** 🞏 New Patient 🞏 Edit Information

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

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| **Patient Information- *Please provide Photo ID*** |

Patient Last Name: Social Security Number:

First Name: MI Date of Birth:

Alias/Preferred Name: \_ Sex: 🞏 M 🞏 F 🞏 Unknown

**Marital Status**: 🞏 Single 🞏 Married 🞏 Widowed Preferred Language: 🞏 English 🞏 Spanish 🞏 Other 🞏 Separated 🞏 Divorced 🞏 Life Partner Need Interpreter? 🞏 YES 🞏 NO Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Significant Other 🞏 Other Hearing Impaired? 🞏 YES 🞏 NO Comments: \_\_\_\_\_\_\_\_\_\_\_\_

 Vision Impaired? 🞏 YES 🞏 NO Comments: \_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: **(Data is used for statistical reporting.)** Race: **(Data is used for statistical reporting.)**

🞏 Central/S Am 🞏 Cuban 🞏 Hispanic or Latino 🞏 Not Hispanic or Latino 🞏 American Indian 🞏 Asian 🞏 African American 🞏 White 🞏

🞏 Mexican 🞏 Puerto Rican 🞏 Patient Refused 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Native Hawaiian/Pacific Islander 🞏 Unknown 🞏 Patient Refused

Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Patient’s Contact Information**  |

**Preferred Method of Contact**: 🞏 Home 🞏 Cell 🞏 Work Home Phone: ( )

🞏 Alt Phone 🞏 Letter 🞏 Email Cell Phone: ( )

**Automated Reminder Calls/Text about Appointment** 🞏 YES 🞏 NO Work Phone: ( )

Alt Phone: ( )

E-Mail: \_\_\_\_\_\_\_ 🞏 No Email 🞏 Patient Refused

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| **Patient’s Primary Address**  |  |  |

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Patient’s Employment Information** |  |  |

**Emp. Status**: 🞏 Full Time 🞏 Part Time 🞏 Retired Employer:

🞏 Unemployed 🞏 Disabled 🞏 Homemaker Address:

🞏 Student 🞏 Active Military 🞏 Self-Employed 🞏 Other City, State, Zip:

 County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_

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| **Patient’s Emergency Contact** |  |  |

Emergency Contact Name.: ­­­­­­ Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Relationship to Emerg. Cont.: Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Name, Address & Phone #:**

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| --- |
|  **INSURANCE INFORMATION** – ***Please provide copies of all cards***(A separate form is required for worker’s compensation, automobile liability, or legal services.) |

**PRIMARY CARRRIER:** Telephone #: ( )

Address: ID/Cert #:

Group/Plan #: Effective Date: Subscriber’s Name:

Subscriber’s DOB: SSN: Sex: 🞏 M 🞏 F 🞏 Unknown Relationship to Patient:

**SECONDARY CARRIER**: Telephone #: ( )

Address: ID/Cert #:

Group/Plan #: Effective Date: Subscriber’s Name:

Subscriber’s DOB: SSN: Sex: 🞏 M 🞏 F 🞏 Unknown Relationship to Patient:

|  |
| --- |
| **Guarantor Information** *(Guarantor is the person financially responsible for this patient’s bill.)* |

**Please complete if guarantor is other than self**

Guarantor: Patient’s Relationship to Guarantor:

Addr: Social Security Number:

City, State, Zip: Date of Birth:

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: 🞏 M 🞏 F 🞏 Unknown

Home Phone: ( ) Cell Phone: ( )

 *(Billing company utilizes TEXTING)*

Guarantor’s Employer: Work Phone: ( ) \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Benefits/Authorization/Notice of Collection Action**

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co‐payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, 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. (Please see the Atlantic Health Partners Payment Policy and Notice of Privacy Practices for more information)

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(Guarantor/Legal Guardian Signature) (Guarantor/Legal Guardian Print Name)

**Please complete this section if the patient is covered by Medicare**

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

Are you or your spouse employed? 🞏 YES 🞏 NO Has treatment been authorized by the V.A.? 🞏 YES 🞏 NO

Do you or your spouse have other insurance? 🞏 YES 🞏 NO Are you covered under the Black Lung Program? 🞏 YES 🞏 NO

Are you disabled or have end stage renal disease? 🞏 YES 🞏 NO Is there Medigap coverage secondary to Medicare? 🞏 YES 🞏 NO

Is illness/injury the result of an auto accident? 🞏 YES 🞏 NO Is there insurance coverage primary to Medicare? 🞏 YES 🞏 NO

Did illness/injury the result of an auto accident? 🞏 YES 🞏 NO Is there employer supplemental coverage secondary

 to Medicare? 🞏 YES 🞏 NO

*The undersigned certifies that the questions have been answered truthfully and hereby 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*

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor/Legal Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Guarantor/Legal Guardian Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_