



HUNTERDON HEALTHCARE SYSTEM

PATIENT REGISTRATION FORM (Primary Care)

Date: _____

PATIENT INFORMATION			
Last Name	First Name	MI	
Mailing Address	Marital Status	M	D S W
City	State	Zip	Sex
Home Phone	Work Phone		
Date Of Birth	SS#	Employer	
Who referred you to our office?	Provider of your choice:		
RESPONSIBLE/CUSTODIAL PARTY (if different than patient)			
Last Name	First Name	MI	
Mailing Address			
City	State	Zip	Sex
Date Of Birth	Relationship To Patient		
Home Phone	Work Phone		
Employer	Social Security Number		
PRIMARY INSURANCE INFORMATION			
Name of Insurance Company			
Name of Subscriber (policy holder)	ID#		
Insured's Date of Birth	Group#		
Name of Employer	Insured's SS# (if different than ID#)		
Subscriber's Relationship to Patient			
SECONDARY INSURANCE INFORMATION			
Name of Insurance Company			
Name of Subscriber (policy holder)	ID#		
Insured's Date of Birth	Group#		
Name of Employer	Insured's SS# (if different than ID#)		
Subscriber's Relationship to Patient			

EMERGENCY

In case of emergency please contact:

Name Phone Relation

QUESTIONS

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

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

Have you received a copy of the "Patient Bill of Rights"? YES NO Initials:

Have you received a copy of the 'Privacy Notice'? YES NO Initials:

We would like to confirm your appointments. Is this acceptable to you? YES NO

At what telephone number should we confirm your appointments:

This number is my: HOME WORK OTHER:

Who should we ask for at this number: Relation to Patient:

ASSIGNMENT/RELEASE/CONSENT TO TREAT

Permission is hereby granted to healthcare providers within this practice to administer such testing, examinations, treatment, and procedures as are deemed necessary in the course of my care. Information about me necessary to substantiate my insurance claims may be released by the healthcare provider involved in my care. 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, for all services rendered on my behalf or on my dependents.

Signature of Responsible Party Date

Please update signature annually if no changes in the above information have occurred:

Signature of Responsible Party

Signature of Responsible Party Date

Signature of Responsible Party Date