HOLY CROSS HEALTH PARTNERS AT ASBURY METHODIST VILLAGE

Patient's First Name_____ M.I._____ Last name_____
Address_____ Apt_____ Home Phone( )_____-_____
CITY_____STATE_____ZIP_____-_____ Cell/Other( )_____-_____
Date of Birth____/_____/_____ Soc. Sec No._____-____-_____ (Please circle) Male Female
Single Divorced Married Separated Widowed
EMAIL ADDRESS_____@_____
Patient's Occupation_____ Employer_____
Employer's Address_____ Phone ( )_____

PHARMACY NAME _____ PHONE ( )_____
PHARMACY LOCATION _____
Who is responsible for this bill? _____Relationship_____
Billing/Responsible Party's Address (*if different from above*)
_____ Phone ( )_____
City_____ STATE___ ZIP_____-_____

Spouse's Name_____ Spouse's Occupation_____
Spouse's Employer_____ Work Phone ( )_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:
Name_____Relationship_____
Address_____ APT_____ Home Phone ( )_____
CITY_____STATE_____ZIP_____-____Work Phone ( )_____

***HOW DID YOU HEAR ABOUT OUR PRACTICE*?_____**

INSURANCE INFORMATION

Do you have health insurance? Yes _____No_____ (*if yes please complete the following information)*

PRIMARY INS_____
Policy ID No._____
Group No._____
Name of Policy Holder_____
SSN of Policy Holder_____-_____-_____
DOB of Policy Holder_____/_____/_____

SECONDARY INS_____
Policy ID No._____
Group No. _____
Name of Policy Holder_____
SSN of Policy Holder_____
DOB of Policy Holder_____

PLEASE READ AND SIGN

This is a authorization for the doctor indicated above to apply for benefits on my behalf and I request that any payments on any unpaid bills for services rendered to me by the doctor and under the Medical Insurance (Part B) portion of the Medicare program or any other contracts services through Medical Service D.C or any other private insurance company listed on this form be made directly to the doctor indicated above for surgical and/or medical services until such time as I revoke this authorization in writing.

I further authorize the release of any necessary medical information for any claim to my insurance carrier. I hereby acknowledge that I am fully responsible for payment of the total bill incurred.

Signature of Policy Holder/Patient/Spouse_____ Today's Date_____