NJ Advanced Surgical Solutions Dr. Prokurat

Tel: 800.920.9928/Fax: 800.615.9936

Patient Registration Paperwork

ALL INFORMATION ON THIS FORM MUST BE COMPLETED

Patient Information

Last Name	First Name		MI
Date of Birth	Age	Home Phone	
Email	Cell Phone		
Address	City	State	Zip Code
Social Security Number	Driver License #	Sex Male Female	
Ethnicity African American Asian White/Caucasian Hispanic/Latino Other Prefer not to answer		Race American Indian Asian White Black or African American Other	
Marital Status Single Married Widow Widower Divorced		Language	
Employer	Occupation	Work Phone	

If insurance is carried by someone other than the patient, please complete this box:

Last Name	First Name		MI
Date of Birth	Age	Home Phone	
Address	City	State	Zip Code
Social Security Number	Driver License #	Relationship to patient	
Employer	Employer Address		
Work Phone	Occupation		

Emergency Contact Information

Name	Relationship	Phone number

Primary Insurance Information

Insurance Company Name	Insurance Phone Number
Policy/Certification Number	Group/Account Number

Secondary Insurance Information

Secondary Insurance Company Name	Insurance Phone Number
Policy/Certification Number	Group/Account Number

Primary Care Physician Information

Primary Care Physician Name	Primary Care Physician Phone Number

Who may we thank for referring you to our office?

	Phone Number

PATIENT RESPONSIBILITIES

Your co-payment, as stated on your insurance card, is due at the time of service. Any additional patient responsibility will be billed to you once your insurance company has processed your claim.
Billing questions should be addressed to our billing service **Capital Medical Billing Solutions, LLC (732) 443-4038.**
If a referral is required for your visits, it is your responsibility to obtain one from your primary care physician prior to your visit.

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

I acknowledge that the information that I have provided is true and correct. I hereby authorize my insurance carrier to make payment directly to **NJ Advanced Surgical Solutions, PC** for services rendered to me or my dependents. I understand that I am fully responsible for any charges incurred for services rendered as well as any costs or fees incurred for collection of this account. I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents.

Responsible Party _____Relation to Patient _____

Responsible Party Signature: _____ Date: _____