Faith Family Health Care
43 Pearl Street • North Plainfield, New Jersey 07060 • phone: (908) 822-9700 • fax: (908) 822-9701

PATIENT REGISTRATION

AC#_____

Last Name: _____ First Name: _____ Middle Name: _____

D.O. B. _____ / _____ / _____ Gender: _____ Social Security Number _____ - _____ - _____

Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( ) Other ( ) _____

Parent / Guardian *(if patient is under 18 years old)* _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell/Mobile Phone _____

Email Address_____

Employer _____

Preferred Pharmacy Name & Address _____

_____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____

Emergency Contact Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

INSURANCE AND BILLING INFORMATION

Name of Insured *(if other than patient)* _____

Relationship to Patient _____ D.O.B:_____ / _____ / _____

Insurance Company _____ Phone _____

Insurance Company Address _____

Insurance ID# _____ Policy/Group#_____

Medicare#_____ Medicaid# _____

--- PG 1 OF 2: FLIP TO PAGE 2 TO COMPLETE FORM & SIGN ---

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TREATMENT AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE DR. BIROTTE-SANCHEZ AND OR OTHER DOCTORS, NURSES AND HEALTH CARE PROFESSIONALS WORKING FOR FAITH FAMILY HEALTH CARE, TO TREAT ME OR MY MINOR CHILD.

I UNDERSTAND IT IS MY RESPONSIBILITY TO PAY FOR SUCH SERVICES EVEN IF I HAVE INSURANCE COVERAGE BENEFITS. I HEREBY ASSIGN SUCH INSURANCE BENEFITS TO FAITH HEALTH CARE AND/OR ITS HEALTH CARE PROFESSIONAL AND AUTHORIZE DIRECT PAYMENT TO THEM FOR SERVICES RENDERED TO ME OR MY MINOR CHILD.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURACE BENEFITS.

I HEREBY AUTHORIZE FAITH FAMILY HEALTH CARE TO RELEASE ANY NECESSARY MEDICAL OR PERSONAL INFORMATION THAT MAY BE NEEDED TO FACILITATE PAYMENT FOR SERVICES.

NAME (please print): _____

SIGNATURE: _____ DATE: _____/_____/_____