ADVANCED HEALTH CENTER, P.C.
Angel M. Carrion, D.C. & Lisa D. Noto, D.C.
335-A Main Street Hackensack, NJ 07601

CONFIDENTIAL PATIENT INFORMATION
PLEASE PRINT

DATE ____/_____/_____

PATIENT INFORMATION:

FIRST NAME: ________________________________

LAST NAME: ________________________________

Sex: □M □F Marital Status: □ Single □ Married

DOB: ____/____/______ □ Widowed □ Divorced

SS#: _______-______-________

ADDRESS: ______________________________ APT#: ________ CITY: ________________

STATE: ______ ZIP CODE: __________ EMAIL: ______________________________

HOME #: (________) __________________ CELL #: (________) __________________

EMERGENCY CONTACT: ____________________ RELATION: ____________ PH: (_______) ____________

EMPLOYMENT STATUS: □ Unemployed □ Part-time □ Full-time □ Retired

EMPLOYER: ______________________________OCCUPATION: ______________________

WORK ADDRESS: ____________________ STATE: ____ ZIP: ________ PH:(_______) ____________ EXT______

HOW DID YOU HEAR ABOUT US? ____________________ DATE SYMPTOMS BEGAN: _____/_____/_______

PRIMARY PHYSICIAN: ____________________ PHONE #: (_____) ____________ LAST VISIT: ____________

FILL OUT BELOW ONLY IF YOU ARE NOT THE PRIMARY ON YOUR INSURANCE

INSURANCE INFORMATION:

PRIMARY INSURANCE: ______________________________ INSURED'S DOB: _____/_____/________

INSURED'S SSN: ______/______/_______ RELATIONSHIP TO INSURED: □ SELF □ SPOUSE □ CHILD □ OTHER

SUBSCRIBER ID #: ______________________________ GROUP #: ______________________________

CITY:____________________ STATE: _______ ZIPCODE: ____________ PH:(_______) ____________________

AUTHORIZATIONS:

1. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

2. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

3. I have read and received a copy of the Financial Policy. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's signature ______________________________ Date__________________

Guardian's signature ______________________________ Date __________________