UROLOGY CARE OF CENTRAL NEW JERSEY, P.A.

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New Patient Information Form

Patient Information Sheet

Date: ___________________________

Name (First, Middle, Last): _______________________________________

Patient's Address: ____

City: __________________________ State: ______________ Zip: _____

Home Phone: _______________________________

Email Address: ________________________

Sex: Male Female

Social Security Number: _________________________________

Age: ___________ Date of Birth: _____________________

Marital Status: Single Married Divorced Widowed

Spouse's Name: ___________________________________

Spouse's Date of Birth: ______________________________

Spouse's Social Security #: ___________________________

Employment Information:

Are you actively employed? Retired?

Work Phone #: ___________________________________

Occupation: ______________________________________

Employer: _______________________________________

Employer Address: __________________________________

City: ______________________ State: ____________ Zip: ___________

Spouse's Employer: __________________________

Work Phone #: ________________________________

Referring Physician:

Name (First, Middle, Last): _____________________________________

Address: ____

City: _________________________ State: _______________ Zip: ________________

Phone: ____________________________________

Complete if Patient is a Minor:

Father's Name: ___________________________________

Work Phone: _______________________________________

Father's Social Security #: _____________________________________

Father's Employer: ____

Mother's Name: ____

Work Phone: _______________________________________

Mother's Social Security #: _____________________________________

Mother's Employer: ____

Person to Notify in Case of Emergency:

Name: ______________________________________

Relationship: ____

Home #: _______________________________________

Work #: _______________________________________

Primary Insurance:

Insurance Company: ____________________________________

Insurance Address: ____

City: ____________________ State: ________________ Zip: ______________

Name of Policy Holder: _____________________________________

DOB: ______________________________________

Policy/ID Number: _____________________________________

Group Number: _______________________________________

Secondary Insurance:

Insurance Company: ____________________________________

Insurance Address: _____________________________________

City: ____________________ State: ______________ Zip: _________________

Name of Policy Holder: ____

DOB: ____

Policy/ID Number: ____

Group Number: ____

We will file your insurance for the companies with whom we are contacted. You will be responsible for any co-payments or deductibles at the time services are rendered. If you have insurance with a company with whom we have no contract, we will file your insurance for any charges over $200.00. You will be responsible for co-payments, deductibles, out of network amounts, or any portion your insurance company states you are responsible for. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will receive a bill at that time. For our HMO/PPO patient's, if we are contracted with your HMO/PPO, you will not receive a bill until we have heard from your insurance company. If you have any questions regarding your insurance, please ask the receptionists.

Assignment to Pay Insurance Benefits:

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Dr. Binod Sinha. This assignment is for services rendered to me by Dr. Binod Sinha. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am **financially responsible** for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment.

I Agree I Do Not Agree

Date: ________________________________