Patient Registration Form

MedStop
STOP AGING · STOP WEIGHT GAIN · STOP ILLNESS

732-366-1000

Appointment Date: _____

PATIENT INFORMATION

Name: _____
Last First Middle Initial

Date of Birth: _____

Primary/Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Gender: ☐ Male ☐ Female

Gender Identification: ☐ Male ☐ Female

Email Address: _____

Phone Number: Home: (_____)_____

Work: (_____)_____

Cell: (_____)_____

Home Address: _____

_____

Mailing Address: ☐ Same as Home Address

_____

_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____

Employer: _____

Employer Address: _____

_____

Employer Phone Number: (_____)_____

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Race/Ethnicity: ☐ American Indian ☐ Asian ☐ Black/African American
☐ Caucasian ☐ Hispanic ☐ Multiracial ☐ Pacific Islander
☐ Other_____ ☐ Unknown ☐ Decline to answer

PARENT/GUARDIAN INFORMATION (If patient is under the age of 18)

Name:_____
Last First Middle Initial

Date of Birth: _____

Email Address: _____

Phone Number: Home: (_____)_____

Work: (_____)_____

Cell: (_____)_____

Home Address: _____

_____

Mailing Address: ☐ Same as Home Address

_____

_____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone Number: (_____)_____

EMERGENCY CONTACT

Name:_____Phone Number: (_____)_____

Relationship: _____

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ACCIDENT INFORMATION

Is this visit due to an accident? ☐ Yes ☐ No ☐ If yes, what type: ☐ Auto ☐ Work ☐ Other: _____

Has it been reported? ☐ Yes ☐ No If yes, to whom? _____

INSURANCE INFORMATION

Do you have health insurance: ☐ Yes ☐ No

Name of policyholder: _____

Date of birth: _____ Phone Number: (_____) _____

Relationship to patient: ☐ Self ☐ Parent/Guardian ☐ Other: _____

Name of carrier (insurance company): _____

Do you have secondary insurance? ☐ Yes ☐ No Name of carrier: _____

FORM COMPLETED BY: ☐ Self ☐ Other: _____

ASSIGNMENT AND RELEASE

I certify that I/my dependent have/has insurance coverage through the carrier listed above. I authorize, request, and assign my insurance company to pay directly to the physician/medical practice, insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether paid by insurance, or not. I hereby authorize the provider/medical practice to release all information necessary to secure the payment of benefits, including but not limited to, diagnosis, records of examinations, records of treatments rendered.

SIGNATURE: _____ **DATE:** _____