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Please fill out this form completely in ink.

May we leave a message? Home: YES☐ or NO☐ Cell: YES☐ or NO☐ Work: YES☐ or NO☐ Email: YES☐ or NO☐

PATIENT INFORMATION

Last:______________________________First:_____________________Middle:______________________
Maiden Name (if applicable):___________________________Birthdate:_______/________/_______
Social Security#________________________Marital Status: Single [ ] Married [ ] Other [ ]_______
Race:____Ethnicity:___________________________________
Address: (Street)____Apt#____________
(City)________________________________(State)____________________(Zip)_______________________
Home#____________________________Cell#_________________________Work#__________________
Pharmacy#____Email:____________________________
Occupation:________________________________Employer:_____________________________________
Employer's Address:____Phone#___________________
Emergency Contact:____Phone#___________________
Primary Care Physician:____Phone#___________________

SPOUSE'S INFORMATION ☐ No Spouse

Last:______________________________First:_______________________Middle:___________________
Birthdate:_______/________/_______ Social Security#_________________________________
Employer:_______________________Employer's Address:______________________________________
Work#:____________________________Ext:______________Cell#:______________________________

PRIMARY INSURANCE ☐Self ☐Spouse ☐Other_______

Policy Holder's Name:__________________________Policy Holder's Birthdate:______/______/______
Insurance Carrier:_____________________Policy ID#:_______________Group#____________________

SECONDARY INSURANCE ☐Self ☐Spouse ☐Other_______

Policy Holder's Name:__________________________Policy Holder's Birthdate:______/______/______
Insurance Carrier:_____________________Policy ID#:___________________Group#________________

I certify that the information I have supplied is accurate and true to the best of my knowledge. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize payment of medical benefits to Advanced Gynecology and Laparoscopy of North Jersey. I authorize Advanced Gynecology and Laparoscopy of North Jersey to use or disclose any information for treatment, payment and health care operations. I authorize that the physician and/or employees of Advanced Gynecology and Laparoscopy of North Jersey can contact me via telephone, e-mail, text, or fax, or leave me a message if they are unable to contact me directly. I have read or received a copy of the Notice if Privacy Practices.

Patient's Signature:____Date:_________________

Guardian's Signature:____Date:________________