Adult & Pediatric Allergist of Central Jersey

1740 Oak Tree Road **260 State Route 34**
Edison, NJ 08820 **Matawan, NJ 07747**

Patient Information (must be completed in full)

Patient Last Name:_____First:_____Sex (M) (F)
Address:_____City, State, Zip:_____
Home Telephone :(__)_____Work Telephone:(__)_____
Cell Phone: _____Birthdate:_____
Soc. Security #_____ Marital Status: (M) (D) (W) (S) Ethnic Origin:_____
Referred By:_____Email:_____Employer: _____
Pharmacy: _____ Pharmacy Phone: _____ Mail Order _____

Responsible Party Information (must be completed in full)

Last Name:_____First Name_____Sex (M) (F)
Address:_____City, State, Zip _____
Home Telephone: ( )_____Work Telephone: ( )_____ _____
Birthdate:_____ _____Social Security #: _____
Employer: _____Occupation: _____

Insurance Information (must be completed in full)

Primary Ins._____ **Secondary Ins._____**
Name of Insured:_____Name of Insured:_____
ID#:_____ ID#:_____
Group #:_____Group #:_____
Address:_____Address:_____
City, State: _____ City, State:_____
Birthdate:_____Sex (M)(F) S.S.#_____Birthdate:_____Sex (M)(F) S.S.#_____
Zip Code:_____Zip Code:_____
Relationship to patient:_____ Relationship:_____
Employer: _____Employer:_____
Date of Employment: _____ Date of Employment: _____
Occupation: _____Occupation: _____

Emergency Notification (must be completed in full)

Last Name:_____First Name:_____
Address:_____
City, State. _____Zip:_____
Telephone (__)_____Relationship:_____

Release of Authorization/Assignment of Benefits

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physician. I agree to make payment as services are rendered. I understand that if for any reason my medical insurance does not make expected payment or if my insurance is terminated, I will be responsible for the total fee. In the event that my bill is sent to collection I will be responsible for the bill itself along with the collection fee.

_____ __/__/_____

(Patient or Representative) **Date**