Please give your Driver's License and Insurance Card(s) to the receptionist with this completed form.

LAST NAME_____ **FIRST NAME**_____**M.I.**_____ **DOB**_____

GENDER M F **SS#**_____ **RACE**_____ **ETHNICITY** HISPANIC or non-HISPANIC

ADDRESS_____ **ZIP**_____ **CITY**_____ **ST**_____

HOME PHONE#_____ **WORK#**_____ **CELL#**_____

PRIMARY LANGUAGE_____ **MARITAL STATUS** S M W

EMAIL _____

COMMUNICATION PREFERENCE (circle one) HOME PHONE CELL PHONE ***Secure*** EMAIL (via Portal)

► *PRIMARY CARE PHYSICIAN*: FIRSTCARE **Other:** _____

► **PHARMACY NAME:** _____ **CITY**_____ **STREET** _____

► **EMERGENCY CONTACT INFORMATION**:

NAME_____ **RELATIONSHIP**_____ **PHONE#**_____

► **RESPONSIBLE PARTY INFORMATION: (if a minor)**

FIRST NAME_____ LAST NAME_____ SS#_____

STREET ADDRESS_____ CITY_____ ST_____ZIP_____

HOME PHONE#_____ WORK#_____ CELL#_____

BIRTHDATE_____ GENDER M F MARITAL STATUS S M D W RACE_____

► **INSURANCE INFORMATION : (Please give your insurance card(s) and DL to the receptionist to be scanned.)**

PRIMARY INSURANCE: _____

SUBSCRIBER: ( ) PATIENT ( ) SPOUSE ( ) PARENT ( ) OTHER_____

NAME_____ DOB _____

SECONDARY INSURANCE:: _____

SUBSCRIBER: ( ) PATIENT ( ) SPOUSE ( ) PARENT ( ) OTHER_____

NAME_____ DOB _____

Notice of Privacy & Billing Practices

Patient Name: _____ Date of Birth: _____

I have been informed that FirstCare Medical Group's Privacy Practices and Billing Practices details are available on their website at www.FirstCareNJ.com

I understand that if the patient identified above had health insurance or has a health plan in which he or she is not eligible for treatment at FirstCare Medical, I am personally obliged to pay all charges at the time of service, but in any case I will pay all charges in full no later then 30 days after services are rendered or receipt of bill, whichever occurs first.

I understand that if FirstCare Medical submits a claim for services rendered to me to the insurance plans I provided, I am obliged to pay FirstCare Medical for any amount identified as a patient responsibility including co-payment, deductible, and co insurance. I am also responsible to pay FirstCare Medical for any and all services for which I am not eligible or are not covered by the insurance. I understand co-payments are due at the time of service and all other balances are due no later than 30 days after the receipt of the bill.

I authorize the release of all medical information to my insurance company as needed to determine reimbursement of claims for services.

Signature: _____ Date: _____

If patient is a minor:

Name of parent or guardian: _____ Relationship to patient: _____

Please provide the name(s) of those people with whom we may disclose your health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

FirstCare Medical uses several prescription tools. If you do not wish to use these please opt-out below:

Electronic Prescription writing with Pharmacy Benefit Management ☐Opt-out

Medvantx - a point of care sample prescription program ☐Opt-out

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Please visit us on the web at

www.FirstCareNJ.com