Face Sheet (Standard)

Please answer all questions fully

Date:

Account Number:

Fischer Family Medicine, P.A.

1191 Fischer Blvd. Toms River, NJ 08753

(732) 506-7888 / Fax (732) 506-7766

Patient Demographics

Name (Last, First, MI)	Social Security	Age	Date of Birth	Sex	Home Phone:	Ethnicity:
					Cell Phone:	Latino ( ) Not Latino ( )
Mailing Address	City	State	Zip Code	Marital Status:		Language:
				E-Mail:		Race:
Employer	City	State	Zip Code	Work Phone		Reminder Preference: Phone ( ) Postal Mail ( )

Responsible Party (FILL OUT IF PATIENT IS UNDER 18 YEARS)

Name (Last, First, MI)	Social Security	Date of Birth	Sex	Home Phone

Address	City	State	Zip Code	Marital Status
Employer	City	State	Zip Code	Work Phone

Primary Provider	Referring Provider	Referring Address	Phone	Fax

Insurance Information

Primary Insurance Company	Subscriber's Name, Date of Birth, SSN	Relationship	Policy Number/Group#	Copay
Second Insurance Company	Subscriber's Name, Date of Birth, SSN	Relationship	Policy Number/Group#	Copay
Third Insurance Company	Subscriber's Name, Date of Birth, SSN	Relationship	Policy Number/Group#	Copay

Emergency Contact Information

Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

Please List Additional Medical Information

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: _____ Date: _____/_____/_____

(Signature of insured or authorized person, patient or parent if minor)