Skylands Medical Group, P.A.

Print Form

Patient Registration/Demographic Form

Patient Enrollment

PLEASE USE LEGAL NAME

First Name: _____ MI: ____

Last Name: _____

Date of Birth: _____ Sex: _____

SS#: _____ Marital Status (S/M/D/W): ____

Driver's License #: _____

Address 1: _____

Address 2: _____

City: _____

State: ____ Zip Code: _____ - _____

Preferred Contact Number: _____

Home Phone: _____

Work Phone: _____ Ext.: _____

Cell Phone: _____

E-mail: _____

Pharmacy Name: _____

Pharmacy City & State: _____

Race: _____ Decline ☐

Ethnicity: _____ Decline ☐

Preferred Language: _____ Decline ☐

Primary Care Physician

Name: _____

Phone: _____

Name of person to contact in case of emergency:

First Name: _____

Last Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____ Ext.: _____

Primary Insurance Information

Insurance Co. Name: _____

ID #: _____ **Group #:** _____

COPAY: $ _____

Address: _____

City: _____ State: ____ Zip: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Sex: _____

Policy Holder SS#: _____

Relationship to Policy Holder: _____

Policy Holder Address: _____

City: _____ State: ____ Zip: _____

Employer Name: _____

Employer Address: _____

City: _____ State: ____ Zip: _____

Secondary Insurance

Insurance Co. Name: _____

ID #: _____ Group #: _____

Address: _____

City: _____ State: ____ Zip: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Sex: _____

Policy Holder SS#: _____

Relationship to Policy Holder: _____

Policy Holder Address: _____

City: _____ State: ____ Zip: _____

Employer Name: _____

Employer Address: _____

City: _____ State: ____ Zip: _____

Tertiary Insurance

Insurance Co. Name: _____

ID #: _____ Group #: _____

Address: _____

City: _____ State: ____ Zip: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Sex: _____

Policy Holder SS#: _____

Relationship to Policy Holder: _____

Policy Holder Address: _____

City: _____ State: ____ Zip: _____

Employer Name: _____

Employer Address: _____

City: _____ State: ____ Zip: _____

Barriers/Impairments:

Visually Impaired ☐ Auditorily Impaired ☐ Language Barrier ☐ Religious/Cultural ☐

None of the Above ☐

Other Barrier/Impairment: _____

_____

Advanced Directive/Living Will:

Do you have an advanced directive/living will? Yes ☐ No ☐

Pharmacy/Medication History:

I authorize Skylands Medical Group to obtain all of my medication history, as is medically necessary, in any format, to provide my medical care.

CLAIM AUTHORIZATION FOR HEALTH INSURANCE AND MEDICARE PATIENTS

HEALTH INSURANCE COMPANY:

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically- related facility to furnish any and all records, medical history, services rendered, or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to the Health Insurer.

I also authorize the insurer to disclose to a hospital or health care service plan, self-insurer or an insurer any medical information obtained if such disclosure is necessary.

If my coverage is under Group Contract held by an employer, an association trust fund, union, or similar entity, this authorization also permits disclosure to them for the purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with the insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents and or heirs, executors and administrators."

MEDICARE:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that Physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

AUTHORIZATION TO PAY:

"I request payment of this claim and, if the payor accepts assignment, authorize payment direct to the physician or supplier for the services described."

PATIENT'S RESPONSIBILITY:

I authorize the physicians and medical personnel to provide necessary medical treatment.

"I verify the accuracy of aforementioned information, and I authorize the release of information as provided above."

"I agree that I am fully responsible to pay all fees charged by the Doctor, regardless of how much my insurance pays. If the Doctor accepts assignment, the deductible and co-payments are my responsibility." For Medicare; Medicare regulations will prevail.

I UNDERSTAND THAT ALL COPAYS ARE TO BE PAID AT THE TIME OF SERVICE.

"I am in agreement with the "Authorization to Pay" and the "Patient's Responsibility to Pay" statements made above."

Signature: _____ **Date:** _____