CENTRAL JERSEY INTERNAL MEDICINE ASSOCIATES PA

# Patient Demographic Form

Please complete this form in order to ensure proper billing of your services.

## PATIENT INFORMATION:

Last Name: ______________________ First Name: ______________________ Date: _____/_____/______

Date of Birth: _____/_____/_____ Age: ______ Soc. Sec. No: _____-_____-_____ Driver Lic. No: ______________

Address: ______________________________ City, State, and Zip: ______________________________

Home Phone: _____-_____-______ Cell Phone: _____-_____-_____ Work Phone: _____-_____-______

Email: __________________________ Primary Language: ______________ Ethnicity: ________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Are we able to leave messages on your answering machine? ☐ YES ☐ NO

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work

## EMPLOYMENT INFORMATION:

Employer: __________________________________ Occupation: ______________________________

Employer Address: ________________________________ City, State, and Zip: ________________________

Employment No.: _____-_____-_____ Employment Status: _________________ Student Status: ____________

## EMERGENCY CONTACT: (FRIEND OR RELATIVE NOT LIVING WITH YOU)

**1.** Contact Name: ______________________________________ Relationship to you: __________________

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

**2.** Contact Name: ______________________________________ Relationship to you: __________________

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

## INSURANCE INFORMATION:

**1.** Primary Insurance Company Name: ______________________________ Telephone: _____-_____-_____

Insurance Company Address: ______________________________________________________________

Insurance Policy ID#: ___________________________ Insurance Group #: ___________________________

Is Insurance through subscriber's Employer? ☐ YES ☐ NO Subscriber's Date of Birth: _____/_____/_____

Name of Subscriber: ______________________________________ Subscriber SS#: _____-_____-_____

Relationship to Subscriber: ______________________________________________________________

**2.** Secondary Insurance Company Name: ____________________________ Telephone: _____-_____-_____

Insurance Company Address: ______________________________________________________________

Insurance Policy ID#: ___________________________ Insurance Group #: ___________________________

Is Insurance through subscriber's Employer? ☐ YES ☐ NO Subscriber's Date of Birth: _____/_____/_____

Name of Subscriber: ______________________________________ Subscriber SS#: _____-_____-_____

Relationship to Subscriber: ______________________________________________________________

## PHARMACY INFORMATION:

Pharmacy Name: ______________________________________________________ ☐ Local ☐ Mail Away

Address: ________________________________________________________________________

Phone #: ________________________________________ Fax #: _____________________________

Pharmacy Name: ______________________________________________________ ☐ Local ☐ Mail Away

Address: ________________________________________________________________________

Phone #: ________________________________________ Fax #: _____________________________

***CONTINUED ON NEXT PAGE*** --------→

**PATIENT CONFIDENTIALLITY- IT IS OUR POLICY TO CALL YOU TO CONFIRM YOUR SCHEDUELED APPOINTMENT AND/OR PROCEDURE AND TO REPORT TEST RESULTS. DUE TO THE PRIVACY RULE, WE CAN ONLY RELEASE INFORMATION TO THOSE LISTED BELOW: *(NAME, RELATIONSHIP AND TELEPHONE NUMBER)***

| Name: | Relationship: | Telephone: |
|---|---|---|
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DO WE HAVE PERMISSION TO RELEASE HEALTH INFORMATION OTHER PROVIDERS IN CHARGE OF YOUR HEALTHCARE? ☐ YES ☐ NO

Do you have an Advanced Directive? ☐ YES ☐ NO

X________________________________________ ______/______/______

*Signature of Patient or Representative* *Date*