HackensackUMC
Maternal Fetal Medicine & Surgery

PATIENT INFORMATION SHEET

PATIENT NAME: _____
Last First Middle

STREET ADDRESS_____ PHONE:_____

TOWN/CITY:_____ STATE:_____ ZIP CODE:_____ MOBILE:_____

DOB: ___/___/_____ SS#:____-____-____ MARITAL STATUS: M S D W X

ALLERGIES:_____ BLOOD TYPE:_____

PATIENT'S EMPLOYER:_____ PHONE#:_____
ADDRESS:_____ CITY:_____ STATE:_____
ZIP CODE:_____:_____ OCCUPATION:_____

SPOUSE:_____ DOB: __/___/_____ SS#:____-____-____

SPOUSE'S EMPLOYER:_____ PHONE#:_____
ADDRESS:_____ CITY:_____ STATE:_____
ZIP CODE:_____:_____ OCCUPATION:_____
REFERRING MD:_____ PHONE#:_____

LAST MENSTRUAL PERIOD:___/___/_____ DUE DATE:___/___/_____ REASON FOR VISIT:_____

*****PAYMENT IS EXPECTED AT THE TIME OF VISIT***** ****INSURANCE IS NOT ACCEPTED AS PAYMENT****

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **POLICY#**_____
GROUP#_____ **ADDRESS:**_____ **CITY:**_____ **STATE:**_____
ZIP CODE: _____ **PHONE #**_____ **SUBSCRIBER:**_____

SECONDARY INSURANCE: _____ **POLICY#**_____
GROUP#_____ **ADDRESS:**_____ **CITY:**_____ **STATE:**_____
ZIP CODE: _____ **PHONE #**_____ **SUBSCRIBER:**_____

I, the undersigned, certify that the above information is true and correct To the best of my knowledge. I understand that I am financially responsible for all charges for services rendered by Hackensack University Medical Center-Maternal Fetal Medicine, whether or not paid by insurance I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

DATE:___/___/____ PATIENT SIGNATURE: X _____

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby assign and request that payment of all medical benefits be made to _____. I understand that I am financially responsible for any and all charges incurred while under the care of said physician, I hereby authorize _____, to release any information required in the course of my examination or treatment.

DATE:___/___/____ SIGNATURE OF INSURED: X _____

DATE:___/___/____ SIGNATURE OF INSURED: X _____