## **NEPHROLOGY HYPERTENSION ASSOCIATES OF CENTRAL JERSEY, PA**

# **REGISTRATION FORM**

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| |  |  |  | | --- | --- | --- | | **Today’s Date:** | **Primary Care Physician:** | **PCP Phone:** |  PATIENT INFORMATION  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Patient’s Last Name:** |  | **First Name:** | **MI:** | **Marital Status:** |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Is this your legal name?** | **If not, what is your legal name?** | **Former name:** | **Birth date:** | **Age:** | **Sex:** | |  |  |  |  |  |  |   **Address:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Social Security:** | **Home phone :** | | | **Cell phone:** | |  |  | | |  | | **Occupation:** | **Employer:** | | | **Employer phone:** | |  |  | | |  | | **Email address:** | |  |  | | |  | |  |  | |   **Referred by:   Reason for referral/Chief Complaint:** INSURANCE INFORMATION**(Please give your insurance card to the receptionist.)**  |  |  |  |  | | --- | --- | --- | --- | | **Primary Insurance Company:** | **Insurance Address:** | **Policy ID:** | **Group #:** | |  |  |  |  | | **Subscriber’s Name:** | **Subscriber’s SSN:** | **Subscriber’s DOB:** | **Copay: $** | | **Employer:** | **Employer Address:** | **Employer Phone:** | **Policy Effective Date:** | |  |  |  |  |   **Patient’s relationship to primary insurance subscriber:**   |  |  |  |  | | --- | --- | --- | --- | | **Secondary Insurance (if applicable):** | **Insurance Address:** | **Policy ID:** | **Group #:** |   **Patient’s relationship to secondary insurance subscriber:**   |  |  |  |  | | --- | --- | --- | --- | | **Subscriber’s Name:** | **Subscriber’s SSN:** | **Subscriber’s DOB:** | **Copay: $** |  IN CASE OF EMERGENCY  |  |  |  |  | | --- | --- | --- | --- | | **Name of local friend or relative:** | **Relationship to patient:** | **Home phone:** | **Cell phone:** | |  |  |  |  |   **The above information is true to the best of my knowledge. I authorize NEPHROLOGY HYPERTENSION ASSOCIATES OF CENTRAL JERSEY, PA to release any 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 I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I AGREE TO REIMBURSE THE FEES OF ANY COLLECTION AGENCY, WHICH MAY BE BASED ON A PERCENTAGE OF THE DEBT AT A MAXIMUM OF 50%, AND ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEYS FEES, INCURRED IN SUCH COLLECTION EFFORTS. I permit a copy of this release to be used in place of the original.**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  | **Patient/Guardian signature** |  | **Date** |  | |  |  |  | |
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Nephrology Hypertension Associates of Central Jersey, PA

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CMS requirement for the new Electronic Health Record (EHR) includes the recording of the patient’s race, ethnicity and preferred language.

Thank you for your cooperation in maintaining your accurate health information.

Please complete the following questions:

What is your race?

* American Indian/Alaska Native
* Asian
* Black/African American
* Hispanic or Latino
* Native Hawaiian/Other Pacific Islander
* White
* Other/Unknown

What is your ethnicity?

* Hispanic or Latino
* Non Hispanic/Latino
* Declined

What is your preferred language?

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