ATLANTIC MEDICAL PHYSICIANS
PATIENT INFORMATION SHEET

PATIENT NAME:	**SOCIAL SECURITY #:**	**DATE OF BIRTH:**
MAILING ADDRESS:		
EMAIL ADDRESS:		
HOME PHONE #:	**CELL/PAGER #:**	**WORK PHONE #:**
EMPLOYER:		
EMPLOYER'S FULL ADDRESS:		
EMPLOYER'S PHONE #:	**PHARMACY-Location & Phone #:**	

REASON FOR VISIT – WAS THIS INJURY RELATED TO: (CHECK ONE):

WORK RELATED? ☐	**AUTO RELATED?** ☐	**HOME RELATED?** ☐

INSURANCE INFORMATION

COMPANY NAME:	**TYPE: (CHECK ONE)** **WORKERS COMPENSATION** ☐ **MEDICAL** ☐/ **AUTO** ☐/ **HOME OWNER'S** ☐/ **OTHER** ☐
COMPANY ADDRESS:	

ID #:	**GROUP #:**	**CLAIM #:**
Subscriber Name:	**Subscriber Date of Birth:**	**Relation to Subscriber:**
COVERAGE EFFECTIVE DATE:		**DATE OF INJURY:**

GUARANTOR INFORMATION (FOR MINORS, SPOUSE OR GUARDIAN)

RESPONSIBLE PARTY: (FULL NAME)	**RESPONSIBLE PARTY SSN:**	**DATE OF BIRTH:**
ADDRESS:		**TELEPHONE #:**
EMPLOYER:		**RELATIONSHIP TO PATIENT:**

IN CASE OF EMERGENCY NOTIFY: NAME, ADDRESS & TELEPHONE #

HOW WERE YOU REFERRED TO OUR OFFICE? (PLEASE CHECK ONE)

☐ **PHYSICIAN (DR.)**	☐ **FRIEND/FAMILY**	☐ **INSURANCE COMPANY**	☐ **EMPLOYER**	☐ **OTHER**

I give and assign you, Atlantic Medical Physicians, the right to ask, demand and collect and receive payment for my medical bills from such insurer or from such other sources as may be obligated for payment. I understand that the assignment of these rights by me does not obligate my physician(s) and Atlantic Medical Physicians to take any action to collect or receive payment from an insurer or other source and I understand that any outstanding balance that my insurance does not cover is my absolute responsibility. This responsibility can only be changed if a prior arrangement was made in writing by Atlantic Medical Physicians,
It is hereby understood that if I falsify any information on this sheet, the balance will then become my full responsibility deemed payable upon demand. It is hereby understood that I am responsible for all deductibles, co-payments, co-insurance and/or services not covered by my insurance plan at the time such services are rendered. It is hereby understood and agreed that I will be responsible for an administrative charge of 1% per month that may be imposed on my bill for any unpaid balance beginning thirty (30) days after receipt of services.
It is further understood and agreed that in the event Atlantic Medical Physicians is forced to take legal action to collect any unpaid balance, that I will be responsible for paying Atlantic Medical Physicians for reasonable attorney fees, costs and interest associated with any and all legal actions as a result of the unpaid balance.

Signed: Date:

Public law in the State of New Jersey mandates that a physician, chiropractor or podiatrist inform his/her patients of any significant financial interest they may have in a healthcare service. Accordingly, we wish to inform you that certain physicians do have financial interests in the following healthcare services to which we could refer out patients:

Atlantic Medical Physicians

Date:

Parent, Guardian, Insured Authorized Signature

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Witness Signature