

REGISTRATION SLIP

(Please print)

RAMAPO VALLEY OB/GYN - PC

Date: _____

Account # _____

NAME _____
Last First Middle Initial

STREET _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ CELL PHONE _____ JOB PHONE _____

BIRTH DATE _____ AGE _____ SS # _____

MARITAL STATUS: Married Single Divorced Widowed

OCCUPATION _____ IN CASE OF EMERGENCY, PLEASE CONTACT:

EMPLOYER NAME _____ NAME _____

EMPLOYER ADDRESS _____ PHONE _____

EMPLOYER PHONE _____ RELATIONSHIP _____

NAME OF SPOUSE _____ SPOUSE'S BIRTH DATE _____ AGE _____

SPOUSE'S OCCUPATION _____ SPOUSE'S EMPLOYER _____

SPOUSE'S EMPLOYER'S ADDRESS _____

SPOUSE'S EMPLOYER'S PHONE _____

REFERRED BY _____

CITY _____ STATE _____ ZIP CODE _____

MEDICARE? Yes No If yes, number _____

IS MEDICARE YOUR: PRIMARY INSURANCE or SECONDARY INSURANCE?

PRIMARY INSURANCE _____

POLICY NUMBER _____ GROUP NUMBER _____

Insured's name, if not the same:

NAME _____
Last First Middle Initial

STREET _____

CITY _____ STATE _____ ZIP CODE _____

INSURED'S SS# _____ INSURED'S DOB _____

Patient's relation to insured: Self Spouse Child Other

SECONDARY INSURANCE _____

POLICY NUMBER _____ GROUP NUMBER _____

Insured's name, if not the same:

NAME _____
Last First Middle Initial

STREET _____

CITY _____ STATE _____ ZIP CODE _____

INSURED'S SS# _____ INSURED'S DOB _____

Patient's relation to insured: Self Spouse Child Other

Does your health insurance pay for a well visit? Yes No

If Patient Is a Medicare Recipient:

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) OR THEIR INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE THIS OFFICE TO FURNISH MY INSURANCE CARRIERS WITH ANY INFORMATION RELEVANT TO MY CLAIM, AND TO MAKE DIRECT PAYMENT WHEN ACCEPTED.

If Patient Is Covered by Health Insurance:

I REQUEST ALL PAYMENTS BE MADE TO THIS DOCTOR DIRECTLY FOR COVERED SERVICES. I AGREE TO PAY ANY AMOUNT THE INSURANCE COMPANY DID NOT OR WILL NOT PAY.

Medigap Waiver:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PROVIDER OF SERVICE AND (OR) SUPPLIER FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER OF SERVICE AND (OR) SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICARE INFORMATION ABOUT ME TO RELEASE TO MY MEDIGAP INSURANCE ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

MEDIGAP Insurance: _____ HIC# _____

SIGNED: _____ DATE: _____