CARING DOCTORS MEDICAL CENTER

240 Bridge Street Metuchen NJ 08840

Patient Name_____ Date of Birth ___/___/___ Age ____

Patient Address_____

(street) (city) (state) (zip code)

Patient Phone#_____ Cell Phone#_____

Email Address_____ Pharmacy Phone#_____

Occupation_____ Employer_____

Employer Address and Phone# _____

Social Security # _____-_____-_____ Sex_____ Marital Status (M) (S) (D) (W)

Emergency Contact Name_____Relationship_____Phone #_____

Allergies_____ Medical Alerts_____

Medications_____

INSURANCE INFORMATION

Insurance Carrier_____ Policy #_____

Subscriber Name _____ Subscribers Date of Birth_____

Relationship to subscriber_____

Secondary Insurance_____ Policy #_____ Subscriber_____

I hereby release any of my medical information to process this claim and also authorize payment directly to Caring Doctors Medical Center, P.C. A photocopy of this assignment shall be valid as the original signature.

I understand payment is expected in full at time of service, unless insurance is accepted. I also understand that if insurance denies payment for any reason, I am responsible for payment.

Signed_____ Date_____

CONSENT FOR TREATMENT: (must be signed before services are rendered)

I hereby voluntarily consent for examination and treatment by the physician of Caring Doctors Medical Center.

Signed_____ Date_____