

# Murray Hill Medical Group

Account #: \_\_\_\_\_

## Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:   M  F    
Marital Status: \_\_\_\_\_ Primary Email Address: \_\_\_\_\_

## Employment Information:

Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Home/Office Fax: ( ) \_\_\_\_\_

## Insurance Information:

**Primary Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscribers SS #: \_\_\_\_\_ Relationship to Insured: [ ]Self [ ]Spouse [ ]Other \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscribers SS #: \_\_\_\_\_ Relationship to Insured: [ ]Self [ ]Spouse [ ]Other \_\_\_\_\_

## Other Required Information:

Referring MD: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
How did you hear about our practice?: \_\_\_\_\_

By providing your credit card information below, you authorize payment for uncovered services and/or those that are determined to be your responsibility by your health plan. **If you choose not to provide your credit card authorization, your account will be subject to a \$25 statement fee per month for any outstanding balance.** Our practice has implemented stringent security measures to protect your credit card information and will make every attempt to contact you prior to charging your account.

Credit Card # ( MC VISA AMEX ) : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp. Date: \_\_\_\_\_ - \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that the information provided is true and accurate. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I authorize payment of medical benefits to Murray Hill Medical Group when assignment has been taken. I have read the office financial policy and agree to all terms and conditions. I authorize Murray Hill Medical Group to use or disclose any information for treatment, payment, and healthcare operations. I authorize that the physicians and/or employees of Murray Hill Medical Group can contact me via all necessary means (phone, email, fax, etc) or leave me a message if they are unable to contact me directly. I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_