



Underwood-Memorial Hospital's Family Medicine Center  
Woodbury, NJ 08096

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB \_\_\_\_\_

Phone No. (\_\_\_\_) \_\_\_\_\_ Cell Phone No. (\_\_\_\_) \_\_\_\_\_ Work No. (\_\_\_\_) \_\_\_\_\_

Marital Status (please circle one):    Single    Married    Divorced    Widowed    Occupation: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**GUARANTOR (Person Responsible for Payment)**

Relationship to Patient (please circle one):    Self    Spouse    Parent    Other : \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address \_\_\_\_\_

Phone No. (\_\_\_\_) \_\_\_\_\_ Work No. (\_\_\_\_) \_\_\_\_\_

**PRIMARY INSURANCE**

Insurance Name \_\_\_\_\_ *Circle one:*    HMO    PPO    TRADITIONAL

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone (\_\_\_\_) \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Social Security #: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_ DOB \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Name \_\_\_\_\_ *Circle one:*    HMO    PPO    TRADITIONAL

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone (\_\_\_\_) \_\_\_\_\_

Subscriber Name/Address \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Have you been informed of your Patient Rights?**    YES    NO    \_\_\_\_\_ (Initials)



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**ADVANCE DIRECTIVE/LIVING WILL**

Do you have an Advance Directive? YES NO (Please circle)

If yes, please supply the office with a copy. If no, this office can offer information that can assist you in making an advance directive.

**\*IN THE EVENT OF A MEDICAL EMERGENCY THE OFFICE WILL CALL THE EMERGENCY MEDICAL SERVICE (911).**

**CONSENT TO TREAT**

I hereby authorize the Family Health Center physicians or whomever they may designate to administer medical treatment on named patient.

SIGN \_\_\_\_\_ DATE \_\_\_\_\_

**AUTHORIZATION TO RELEASE HEALTH INSURANCE INFORMATION**

I HEREBY AUTHORIZE Underwood-Memorial Hospital's Family Health Centers to release any information in the course of medical examination or treatment for insurance claim filing. I also authorize the release of information to other physicians and health professionals when necessary to help in my medical care. Photostat of this authorization shall be considered as effective and valid as the original.

SIGN \_\_\_\_\_ DATE \_\_\_\_\_

**GENERAL INSURANCE AUTHORIZATION**

I authorize payment of medical benefits on my behalf to physician or supplier for services rendered to me.

SIGN \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICARE AUTHORIZATION**

\_\_\_\_\_  
Name of Beneficiary Medicare Number

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service."

"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 (Name of Medigap Insurer) any information needed to determine these benefits payable for related services."

SIGN \_\_\_\_\_ DATE \_\_\_\_\_

**HIPAA (Healthcare Insurance Portability & Accountability Act) – The Privacy Rule**

I have been provided access to the Notice of Privacy Practices at this time or during a previous visit, and have been given an opportunity to read it.

SIGN \_\_\_\_\_ DATE \_\_\_\_\_

**VIDEO MONITORING AND VIDEO RECORDING CONSENT FORM**

I hereby authorize the video monitoring and/or video recording of medical consultation at the Underwood-Memorial Hospital Family Medicine Center. I authorize the use of the video monitoring and/or video recording solely for the medical education of physicians in training (residents) and/or medical students at Underwood-Memorial Hospital. I understand that any video recording will not be part of my medical record and will be considered to be and treated as a confidential recording. I understand that I have the right to withdraw my consent at any time. I understand that any video recording will be destroyed when no longer needed for educational purposes or in accordance with the Hospital's retention policy.

Patient/Guardian: \_\_\_\_\_

Dated: \_\_\_\_\_

Witness: \_\_\_\_\_

Dated: \_\_\_\_\_

Next of Kin/Legal Guardian: \_\_\_\_\_

Dated: \_\_\_\_\_