Advanced Cardiology LLC/Advanced Primary Care

Patient Registration/Demographic Form

Patient Enrollment

PLEASE USE LEGAL NAME

First Name: _____ MI: ___

Last Name: _____

Date of Birth: _____ Sex: _____

SS#: _____ Marital Status (S/M/D/W): ___

Address 1: _____

Address 2: _____

City: _____

State: ___ Zip Code: _____ - _____

Preferred Contact Number: _____

Home Phone: _____

Work Phone: _____ Ext.: _____

Cell Phone: _____

E-mail: _____

Pharmacy Name: _____

Pharmacy City & State: _____

Race: _____ Decline ☐

Ethnicity: _____ Decline ☐

Preferred Language: _____ Decline ☐

Primary Care Physician

Name: _____

Phone: _____

Name of person to contact in case of emergency:

First Name: _____

Last Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____ Ext.: _____

Primary Insurance Information

Insurance Co. Name: _____

ID #: _____ **Group #:** _____

COPAY: $ _____

Address: _____

City: _____ State: ____ Zip: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Sex: _____

Policy Holder SS#: _____

Relationship to Policy Holder: _____

Policy Holder Address: _____

City: _____ State: ____ Zip: _____

Employer Name: _____

Employer Address: _____

City: _____ State: ____ Zip: _____

Secondary Insurance

Insurance Co. Name: _____

ID #: _____ Group #: _____

Address: _____

City: _____ State: ____ Zip: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Sex: _____

Policy Holder SS#: _____

Relationship to Policy Holder: _____

Policy Holder Address: _____

City: _____ State: ____ Zip: _____

Employer Name: _____

Employer Address: _____

City: _____ State: ____ Zip: _____

Tertiary Insurance

Insurance Co. Name: _____

ID #: _____ Group #: _____

Address: _____

City: _____ State: ____ Zip: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Sex: _____

Policy Holder SS#: _____

Relationship to Policy Holder: _____

Policy Holder Address: _____

City: _____ State: ____ Zip: _____

Employer Name: _____

Employer Address: _____

City: _____ State: ____ Zip: _____

ADVANCED CARDIOLOGY LLC
ADVANCED PRIMARY CARE

Office Locations:

Cedar Knolls, NJ *Hackettstown, NJ*
Newton, NJ *Washington, NJ*

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Cardiology/Advanced Primary Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by requesting one now or by forwarding a written request to Advanced Cardiology LLC/Advanced Primary Care, 65 Ridgedale Ave, Cedar Knolls, NJ 07927 ATT: Privacy Officer.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I give my permission to release information/results on my medical condition to the following:

Mother/Father: _____ Husband/Wife: _____

_____ _____

Son/Daughter: _____ Other: _____

_____ _____

_____ PLEASE DO NOT RELEASE ANY INFORMATION ABOUT ME TO MY FAMILY OR ANYONE WITHOUT MY PERMISSION.

Patient Name (Print): _____

Relationship to Patient (If under age 18): _____

Signature: _____ Date: _____