New Jersey Orthopaedic Institute

Patient Information

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	Sex:
City:	Language:
State: Zip:	Employer:
Home Phone #:	Emergency Contact:
Cell Phone #:	Emergency Phone:
Email:	Emergency Relationship:

Guarantor Information

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	
City:	
State: Zip:	Employer:
Home Phone #:	Employer Address:
Work Phone #:	Employer City:
Cell Phone #:	Employer State: Zip:

Insurance Information

Primary Insurance:	Secondary Insurance:
Member ID #:	Member ID #:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider.

Authorization To Release Medical Information: I hereby authorize New Jersey Orthopaedic Institute to release any information necessary for my course of treatment.

Cancellation Policy: Please note a $25.00-dollar charge will be collected if an office appointment is canceled without a 24-hour notice. Please note a $250.00-dollar charge will be collected if a scheduled surgery is canceled less than 7 days of the planned procedure, without medical reason.

By signing below, I understand that I am fully responsible should my insurance not cover any services. I also agree to be fully responsible for any and all collection fees, attorney fees and/or court fees New Jersey Orthopaedic Institute may incur for collection of my outstanding balance.

_______________________________ _______________________

Signed (patient or parent if minor) Date