UNIVERSITY REHABILITATION ASSOCIATES
(Patient Registration Form)

Please verify the completed information for accuracy and provide all missing information. If an item does not apply, write N/A.

1. Name________________________________ **2.** Date Of Birth___/___/___ **3.** Sex –M –F
4. Home Phone (___) -______ **5.** Cell Phone # (_____)_______________ **6.** Pager # (______)_____________
7. Social Security #_____-____-______
8. Address______________________ City__________________ State_______ Zip_____________
9. Parent/Guardian_________________ Address (if different)_________________________

9. To assist with your care, medical/appointment information can be left at your phone #s unless you cross out this line.
10. In case you are in a life threatening situation would you like to be kept on life support? Yes No Undecided
11. Race ___________ **11.** Marital Status Single Married Legally Separated Divorced Widowed
12. Are you an organ donor? -Yes -No **13.** Religion ________________ Church ________________
14. Your maiden name __________________ **15.** Mother's maiden name ______________________

16. PATIENT'S EMPLOYER_______________________________
17. Status Full-time Part-time Retired Unemployed **18.** Employment Date _____/_____/________
19. Department__________________ **20.** Occupation ________________ **21.** Phone (___) -________.
22. Address__________________________ City__________________ State_____ Zip_____

NEAREST RELATIVE
23. Name_____________________________ **24.** Relationship to the patient__________________
25. Home Phone (___) -________ **26.** Work Phone (___) -________ Cell Phone (___) -__________.
27. Address__________________________ City__________________ State_____ Zip__________

EMERGENCY CONTACT (not living with you)
28. Name_____________________________ **29.** Relationship to the patient__________________
30. Home Phone (___) -________ **31.** Work Phone (___) -________Cell Phone (___) -__________.
32. Address__________________________ City__________________ State_____ Zip__________

33. Is this the result of an auto accident? Y N If yes, where in the vehicle were you? –Driver; –Passenger; Other______

34. Is this the result of a work-related injury? Y N

35. Date of accident____/_____/______ Time _____:_____ **36.** Has a claim been established? Y N
37. Attorney name_______________________ **38.** Attorney phone # (____) -________

INSURANCE INFORMATION
39. Company__________________________________ **40.** Phone (____) -________
41. Address:__________________________ City:__________________ State:_____ Zip:__________
42. Policy #________________ **43.** Group #________________ **44.** Adjuster_____________________
45. Relation to insured Self Spouse Child Other
46. Insured_______________________ **47.** Insured's SSN_______-_____-______ **48.** Insured's DOB____/____/_____

OTHER INSURANCE
49. Company__________________________________ **50.** Phone (____) -__________
51. Address__________________________ City__________________ State_____ Zip__________
51. Policy #________________ **52.** Group #________________ **53.** Adjuster:_____________________
54. Relation to insured Self Spouse Child Other
55. Insured_______________________ **56.** Insured's SSN_______-_____-______ **57.** Insured's DOB____/____/_____

58. Referred by______________________________
If you have an HMO:

- **It is the <u>patient's responsibility</u> to know whether a referral is needed to see our physician(s) and to bring it at the time of the visit.**
- **If no referral is brought in, a referral can not be obtained after the visit and bill for the visit can not be submitted later to the insurance company as per New Jersey State and federal guidelines.**
- **Although we will try to assist you in any way reasonably possible, it is also the patient's responsibility to know what is covered by his/her contract.**
- **<u>Co-pays are due at the time of the visit</u>.**
- **If patient does not supply referral and chooses to go out of network, they can not submit bill to insurance company.**
  Please sign and date ________________________________ if you choose to self pay for office visit.

Outstanding deductible payments are expected at time of service unless special arrangements are made.

I certify that outpatient services were rendered to me at the place of service indicated on this date. I hereby authorize release of information needed to collect from my insurance carrier and authorize payment directly to University Rehabilitation Associates of any insurance benefits otherwise payable to me for this visit. I also understand that I am financially responsible for all charges whether or not covered by insurance. (Valid for 90 days, according to NJ state law.)

Patient's signature ____________________________________ Date signed: ______/______/______.