Harvey R. Gross, MD PC

370 Grand Avenue, Suite 102, Englewood, NJ 07631 ▪ Phone 201 567 3370 ▪ Fax 201 816 1265 ▪ Web: www.primarycarenj.com

Patient Registration Form

Do you have your PIN for the Patient Portal? ☐ Y ☐ N

Patient Information

Patient's Last Name: _____ MI: _____ First Name: _____

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Social Security Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Retired ☐ Disabled ☐ Visually / Hearing Impaired

Race/Ethnicity: ☐ African American or Black ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American
☐ Other _____ ☐ Patient Declined

Primary Language: ☐ English ☐ Chinese ☐ Spanish ☐ Other _____ ☐ Patient Declined

Address: _____

_____

City: _____

State: _____ Zip Code: _____

Preferred Method of Contact via:
☐ Home # ☐ Cell Phone # ☐ Work # ☐ E-mail

Home #: _____

Cell Phone #: _____

Employer of Insured: _____ Email: _____

Patient's Occupation: _____ Work #: _____ Ext: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Are you here because of (an): Auto Accident? ☐ Yes ☐ No **Worker's Compensation?** ☐ Yes ☐ No
If you answered yes on the above, please tell us now and provide us with ALL information.

Assigned Provider (doctor that you are seeing): ☐ H.Gross, MD ☐ S.Ye, MD ☐ E.Ho, MD ☐ A.Skarimbas, MD
☐ M. Loewinger, MD ☐ A.Volokhov, MD ☐ J.Zimmerman, MD

Referring Physician: _____

Guarantor (person responsible for the bill)

Is the patient responsible for the bill? ☐ Yes ☐ If No, please provide details below.

Patient's Relationship to Guarantor: _____

Last Name of Person Responsible for Bill: _____ MI: _____ First Name: _____

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Social Security Number: _____

Address: _____

_____

City: _____

State: _____ Zip Code: _____

Home #: _____

Cell Phone #: _____

Work #: _____ Ext: _____

Email #: _____

Primary Insurance Information

If **No insurance**, ☐ **Self-Pay**

Primary Insurance Company: _____ Insurance ID #: _____

Address: _____ Group ID #: _____

_____ Effective Date: _____/_____/_____

City: _____ State: _____ Zip Code: _____

Is the patient the owner of the policy? ☐ Yes ☐ If No, please provide details below.

Last Name of Policy Owner: _____ MI: _____ First Name: _____

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Social Security Number: _____

Address: _____ Home #: _____

_____ Cell Phone #: _____

City: _____ State: _____ Zip Code: _____

Employer of Insured: _____ Work #: _____ Ext: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance Information

☐ **No Secondary Insurance**

Secondary Insurance Company: _____

Address: _____ Insurance ID #: _____

_____ Group ID #: _____

City: _____ State: _____ Zip Code: _____ Effective Date: _____/_____/_____

Is the patient the owner of the policy? ☐ Yes ☐ If No, please provide details below.

Last Name of Policy Owner: _____ MI: _____ First Name: _____

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Social Security Number: _____

Address: _____ Home #: _____

_____ Cell Phone #: _____

City: _____ State: _____ Zip Code: _____

Employer of Insured: _____ Work #: _____ Ext: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Pharmacy

Pharmacy: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Do you have any Allergies? ☐ Yes ☐ No

If yes, please specify _____

Smoking Status

☐ Current Everyday smoker ☐ Current Someday Smoker ☐ Former Smoker ☐ Never Smoked

Advanced Directive

Please check ALL that apply: ☐ Living Will ☐ Power of Attorney ☐ DNR (Do Not Resuscitate) ☐ Other _____

Have you provided us with copies of ALL of your Advance Directives? ☐ Yes ☐ If No, please provide us copies for your medical records.

Contact Information

Who do we contact in case of an emergency?

Emergency Contact: _____ Relationship: _____ Phone #: _____

Who takes care of the patient?

Parent/Guardian: _____ Relationship: _____ Phone #: _____

or

Caregiver: _____ Phone #: _____

I verify that the information I have provided is accurate.

Patient's Signature: _____ Date: _____/_____/_____

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PRIVATE INSURANCE Authorization

I authorize the release of medical information necessary to process claim forms and the payment of medical benefits to named provider for medical services rendered. A copy of this authorization shall be valid as the original.

Full Name: _____ Relationship: _____
Please Print

Signature: _____ Date: _____/_____/_____

MEDICARE Lifetime Signature on File

I authorize any holder of my medical or other information to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or any other related MEDICARE claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to MEDICARE assignment of benefits apply.

Full Name: _____ Relationship: _____
Please Print

Signature: _____ Date: _____/_____/_____

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HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you would like to obtain a full copy of the HIPAA Notice of Privacy for your records or if you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or by phone at our main phone number, 201 567 3370.

Signature below is only an acknowledgement that you have reviewed this notice of privacy practices posted in the waiting room.

Family members or others you authorize us to discuss your protected health information with:

Person's Last Name: _____ First Name: _____

Phone Number: _____ Relationship: _____

Person's Last Name: _____ First Name: _____

Phone Number: _____ Relationship: _____

Person's Last Name: _____ First Name: _____

Phone Number: _____ Relationship: _____

Expiration Date of Authorization
This authorization is effective unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Harvey R. Gross, MD, PC.
You should contact the office manager to terminate this authorization.

I verify that the information I have provided is accurate.

Person's Last Name: _____ First Name: _____

Patient's Signature: _____ Today's Date: _____/_____/_____

Missed or Cancelled Appointments

1. If you are unable to keep an appointment, we ask that you kindly provide us with at least 24-hour notice.
2. Patients that miss or cancel their Appointment with a specialist, Dr. Jerald Zimmerman with less than 24-hour notice, will be charged a NO SHOW or FAIL TO CANCEL fee.

Your Co-pay

As per your insurance contract, your Co-pay is due at the time of Service and must be paid, without exception.

You are responsible for all charges incurred during your visit including any amounts not paid by the insurance.

Your Insurance Deductible

Please understand that you will be responsible for full payment of your bill if you have a deductible on your insurance plan or if you do not notify us at the time of your visit of your current insurance information.

In the event you default on your account balance, the account will be forwarded to a collection agency.

Patient's Full Name: _____

Please Print

Patient's Signature: _____ Date: _____/_____/_____

Please complete this form.

Family History Update Form

Please check off any family history on each side of your family.

Family History	Maternal Mother's side	Paternal Father's Side
Alzheimer's	☐	☐
Allergies	☐	☐
Stroke	☐	☐
Hypertension	☐	☐
Asthma	☐	☐
Heart Disease	☐	☐
Diabetes Mellitus	☐	☐
CAD (Coronary Artery Disease)	☐	☐
CHF (Congestive Heart Failure)	☐	☐
COPD (Chronic Obstructive Pulmonary Disease)	☐	☐
Hyperlipidemia	☐	☐
PVD (Peripheral Vascular Disease)	☐	☐
Migraine Headache	☐	☐
Breast Cancer	☐	☐
Colon Cancer	☐	☐
Lung Cancer	☐	☐
Ovarian Cancer	☐	☐
Prostate Cancer	☐	☐
Skin Cancer	☐	☐
Stomach Cancer	☐	☐
Pancreatic Cancer	☐	☐
Uterine Cancer	☐	☐
Bladder Cancer	☐	☐
Other: please specify _____	☐	☐
None of the Above – No Family Medical History	☐	☐

Last Name: _____ **First Name**: _____ **DOB**:___/___/___

REMINDERS:

Please remember to write your full name and Date of Birth above.

Please give this form to the Medical Assistant who takes you in the room.