



140 Mt. Holly Bypass Unit 5
Lumberton, NJ 08048
Phone 609-267-1555
Fax 609-267-1566

PATIENT REGISTRATION

PLEASE PRINT & FILL IN ALL REQUESTED INFORMATION

PATIENT INFORMATION

Name: Last: \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_
Home phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_
Home Address \_\_\_\_\_ Apt # \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
(If Different) Billing Address \_\_\_\_\_ Apt # \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_
Employer name \_\_\_\_\_ Address \_\_\_\_\_
Work phone \_\_\_\_\_ (Ext.) \_\_\_\_\_
Emergency contact name \_\_\_\_\_ Phone \_\_\_\_\_
Your relationship to contact? \_\_\_\_\_

REFERRING DOCTOR INFORMATION

Who referred you to this office? \_\_\_\_\_
Who is your primary care physician? \_\_\_\_\_
Phone: \_\_\_\_\_ Fax \_\_\_\_\_

INSURANCE INFORMATION

PRIMARY INSURANCE NAME \_\_\_\_\_ Policy # \_\_\_\_\_
Authorization # \_\_\_\_\_ Group # \_\_\_\_\_
Claims address \_\_\_\_\_
Policyholder name \_\_\_\_\_ Relationship to you: \_\_\_\_\_
Policyholder social security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_
SECONDARY INSURANCE NAME \_\_\_\_\_ Policy # \_\_\_\_\_
Authorization # \_\_\_\_\_ Group # \_\_\_\_\_
Claims address \_\_\_\_\_
Policyholder name \_\_\_\_\_ Relationship to you: \_\_\_\_\_
Policyholder social security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

PLEASE READ & SIGN: I authorize my insurance benefits to be paid directly to Burlington County Endoscopy Center. I understand that it is my responsibility to pay any applicable co-payments, deductibles, co-insurance, and any other balance not paid for by insurance. I understand that it is my responsibility to obtain a valid referral, if applicable, for all visits and if any claim is denied for no referral then I may be responsible for payment. I understand that it is my responsibility to advise the practice of any changes to any of the above information and if any claim is denied as a result of not advising the center then I may be responsible for payment. I hereby authorize the doctor and/or the practice to release all information necessary to secure the payment of benefits. I authorize and assign all benefits to be paid directly to the Burlington County Endoscopy. I agree that a photocopy of this agreement shall be as valid as the original. I acknowledge that my physician may have ownership in Burlington County Endoscopy Center.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_