Barnabas Health | RWJBarnabas HEALTH
Medical Group

Today's Date: _____

Patient ID # _____ (for office use only)

Referring Physician _____

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender M ☐ F ☐ Social Security#: _____

For Minors please indicate responsible Parent/Guardian: _____

Address: _____
Street City State/Zip

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Email: _____ Driver's License#: _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Employer: _____ Occupation: _____

Emergency Contact: _____ Telephone: _____

How did you hear about us?

Please check as many corresponding boxes that apply:

Website	☐	Facebook	☐
Google/Yahoo/Bing	☐	Other Internet Ad	☐
Newspaper/Magazine Ad	☐	Direct mailing (letter, postcard, etc.)	☐
Friend or family _____	☐	Physician	☐
Other (e.g.CVS) _____	☐		

I would like to receive email newsletters, general health tips and information from Barnabas Health: Yes ☐ No ☐

If yes, please provide email address: _____

Responsible Party
Complete only if Patient is Not the Responsible Party

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Insurance Information (Present Insurance Card(s) to Receptionist

Primary Insurance: _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Effective Date of Primary Insurance: _____

Subscriber Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Secondary Insurance: _____ Policy/ID #: _____

Group/Plan #: _____ Relationship to Subscriber: _____

Effective Date of Secondary Insurance: _____

Subscriber Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex (M/F): _____

Address: _____ City/State: _____ Zip: _____

Home Telephone: ( ) _____ Work Telephone: ( ) _____

Demographic Information Request

In order to comply with federal regulations, we are required to ask you for the following information:

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Patient Declined

Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Patient Declined

Advance Directives

Do you have a health care proxy/living will? ☐ Yes ☐ No Do you want to discuss this with your physician? ☐ Yes ☐ No

Smoking Status

Please indicate your smoking history:

☐ Never Smoked ☐ Past Smoker ☐ Current smoker – Indicate how many and how often you smoke _____

Communication Preferences

I understand that the staff and/or physicians of Barnabas Health Medical Group ("BHMG") may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Preferred Language _____ Preferred method for communication: ☐ Home ☐ Work ☐ Cell

Can we leave a message on machine or with whoever answers? (Circle **Yes** or **No**) **Home** Y / N **Work** Y / N **Cell** Y / N

DO NOT CALL: ☐ Home ☐ Work ☐ Cell

Disclosure to Designated Family/Friends/Caregivers

I allow BHMG to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing any time.

Print Name	Date of Birth	Relationship	Phone Number