Integrated Medicine Alliance, P.A.

PO Box 8519, Red Bank, NJ 07701

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT: _____ Home Phone: _____
Last First Middle

Street Address: _____ Cell Phone: _____

Street Address: _____ Work Phone: _____

You have my permission to leave messages on my voicemail, answering machine, or answering service for the following numbers:
Home: ☐ Cell: ☐ Work: ☐

City: _____ State: _____ Zip: _____ Email: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Social Security #: _____

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Civil Union ☐Student (Parents: _____)

Race (check all that apply):☐American Indian ☐Asian☐Black/African American ☐Hawaiian/Pacific Islander ☐Caucasian/White ☐Decline to Report

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic or Latino ☐Decline to Report Preferred Language: _____

Primary Care Physician (PCP): _____
Name Address Phone

Employer Name: _____ Occupation: _____

Employer's Address: _____

How did you hear about our office? ☐Family Member ☐Friend/neighbor ☐Phone Book ☐Other: _____

Emergency Contact: _____ Relationship: _____

Day Time Phone: _____ Night Time Phone: _____

INSURANCE INFORMATION: Please give your insurance card(s) to office staff so we may photocopy them.

PRIMARY INSURANCE: _____ Copayment: _____

Group Name/Group ID#: _____ Insurance ID#: _____

Name of Insured: _____ SSN:____-____-_____ Birth Date: _____ Relationship: _____

SECONDARY INSURANCE: _____ Copayment: _____

Group Name/Group ID#: _____ Insurance ID#: _____

Name of Insured: _____ SSN: ____-____-_____ Birth Date: _____ Relationship: _____

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned authorize payment of medical benefits to Integrated Medicine Alliance, PA for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my insurance contract. I also authorize you (IMA) to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Signed: _____ Date: _____
(NAME PARENT/GUARDIAN IF CHILD UNDER 18 YEARS OLD)

Medicare Lifetime Signature on File:
I request that payment of authorized Medicare benefits be paid on my behalf to Integrated Medicine Alliance, PA for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

Signed: _____ Date: _____
(NAME PARENT/GUARDIAN IF CHILD UNDER 18 YEARS OLD)