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: ________________________________

City: ______________________________ State: _____ Zip: ____________ Work Phone: ______________________________

Date of Birth: ___________________________ Email: ___________________________________ Sex: ☐ Male ☐ Female

Social Security #: ________________________
Patient 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 ☐Internet ☐Other: _____________________

Emergency Contact: ___________________________________Relationship: ______________ 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#: ___________________________________

Subscriber: ___________________________ SSN:_____-_____-______ Birth Date: __________ Relationship to patient__________
Subscribers
Street Address:________________________________City:________________________State:_________Zip:_________________

SECONDARY INSURANCE: ____ Copayment: ________________

Group Name/Group ID#: _____________________________________ Insurance ID#: ____________________________________

Subscriber: ___________________________ SSN: _____-_____-______ Birth Date: __________ Relationship: ________________
Subscribers
Street Address:________________________________City:________________________State:_________Zip:___________________

☐ Financially responsible individual is the same as the Insurance Subscriber identified above. If not, complete section below:

Name of responsible party:____Relationship to patient:_______________________________

Date of Birth:_______________________ SSN:______________________________ Phone:_____________________________________

Street Address:________________________________City:________________________State:_________Zip:______________________

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)