

**Registration :**

**Advanced Musculoskeletal Centers, PA**

Date	Account ID	Chart ID	Other ID	Internal Use
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<b>Patient Information</b>							
Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:		How did you hear of us?		
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact		Phone	Pharmacy			Pharmacy Phone	

<b>Physician</b>	<b>Family Physician</b>	<b>Referring Physician</b>
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Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

<b>Guarantor (Person to be billed, if different than patient)</b>							
1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #	
Address			Home:		Work:	Email:	
City			State	Zip Code	Employer Name & Address		Occupation
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #	
Address			Home:		Work:	Email:	
City			State	Zip Code	Employer Name & Address		Occupation

<b>HIPAA Approved Contacts</b>							
1 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship	
Address		City	State	Zip Code	Home:	Cell:	Work:
2 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship	
Address		City	State	Zip Code	Home:	Cell:	Work:

<b>Patient's or Authorized Person's Signature</b>		
<p>I the undersigned give my authorization to treat and assign directly to Advanced Musculoskeletal Centers, PA , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.</p> <p>I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.</p>		
Signature	Signature Date	<p><b>Advanced Musculoskeletal Centers, PA</b>                  131 Madison Avenue, Suite 130 Phone: 973-538-8336                  Morristown, NJ 07960 Email: Amcortho@optonline.net</p>
<b>X</b>		

Please attach all pertinent insurance ID cards for photocopying.