

**PLEASE PRINT CLEARLY - CENTRAL JERSEY HAND SURGERY - PATIENT INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ M.I.: \_\_\_\_ AGE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_  
BIRTH DATE: \_\_\_\_\_ SS#: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
SEX \_\_\_\_ MARITAL STATUS \_\_\_\_ HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
FAMILY MD NAME, ADDRESS & PHONE #: \_\_\_\_\_  
REFERRED BY (& ADDRESS, if MD): \_\_\_\_\_ Do not call me at work

EMPLOYER NAME: \_\_\_\_\_ WORK NUMBER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

INSURANCE CO. NAME: \_\_\_\_\_ ID: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_  
INSURED'S NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
INSURED'S ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_  
INSURED PHONE: \_\_\_\_\_ SS#: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

INSURANCE CO. NAME: \_\_\_\_\_ ID : \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_  
INSURED'S NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
INSURED'S ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_  
INSURED PHONE: \_\_\_\_\_ SS#: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

DESCRIPTION OF PROBLEM: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_  
DO YOU HAVE? (Please check) DIABETES \_\_\_\_ HYPERTENSION\_\_ HEART DIS\_\_ CANCER \_\_ SMOKE\_\_ HEPATITIS\_\_ HIV+ \_\_\_\_  
MEDICATIONS: \_\_\_\_\_ HAND INJURED: RT \_\_ LT \_\_  
KNOWN ALLERGIES: \_\_\_\_\_ CHECK ONE: RIGHT HANDED \_\_\_\_  
LEFT HANDED \_\_\_\_  
PREVIOUS SURGERIES: \_\_\_\_\_

If CJHS participates in your health insurance, we will bill your carrier for any eligible charges that you incur. We will assist you in obtaining authorization for HMO and Managed Care treatments, but **YOU** are responsible for making sure that the appropriate **referrals** are acquired and are **up to date** with the appropriate number of treatments approved. **You are responsible** for the payment of any co-insurance amounts, non-covered charges, and denied claims. **If CJHS does not participate in your health insurance**, you are responsible for payment of charges **at the time of service**. You are responsible for any balance remaining after ins. payment to our office. If your ins. co. has not paid a claim we submitted for you w/in 60 days, payments is your responsibility. It is your responsibility to notify your insurance co., & **obtain pre-authorization**, if any surgery or hospital admission is planned. We will be happy to assist you in determining your likely balance due after expected insurance payment & can help arrange a method of payment. Your health ins. is a contract between you & your insurance co. We cannot accept responsibility for negotiating any type of settlement on a disputed claim if your pre-authorization is not obtained.

I hereby authorize payment from the insurance company to be sent **directly** to Central Jersey Hand Surgery for any service rendered to me by the group. I also authorize the release of medical information to my insurance company in order for Central Jersey Hand Surgery to complete the necessary ins. forms.. I am aware that the practice of medicine & surgery is not an exact science and acknowledge that no guarantees will be given to me concerning the results of any treatment or operation. Drs. Pess, Decker, Gabuzda, Atik & Fedorcik will attempt to improve the patient, but cannot return the patient to **normal status**.

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

