JEFFERSON FACULTY FOUNDATION

Thomas Jefferson University Hospital
Jefferson Health System

Account No.	Entered Date
Reg. By	Office Site

Patient Registration Form

Please complete this form in order to ensure proper billing of your service. **Please Print**. Today's Date: _____

Patient Name: _____ Social Security Number: _____

First Name _____ Date of Birth: _____

Other Name_____ Race: **(Response is not mandatory. Data is used for statistical reporting.)**

Marital Status: ❑single ❑Married ❑widowed ❑ African American ❑Asian/Oriental ❑Caucasian ❑Hispanic
❑Separated ❑Divorced ❑Other ❑Native American ❑Other ❑Unknown

Addr 1: _____ Home Phone: (____) _____

Addr 2: _____ Home Phone: (____) _____

City, St, Zip: _____

Employer:_____ Emp Status: ❑ Employed Full Time ❑Employed Part Time

Addr 1: _____ ❑Unemployed ❑Disabled ❑Homemaker

Addr 2: _____ ❑Student ❑Active Military ❑Self-Employed ❑Other

City, St, Zip:_____ Work Phone (_____) _____

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor:_____ Patient's Relationship to Guarantor:_____

Addr 1; _____ Social Security Number: _____

Addr 2 _____ Date of Birth: _____

City, St, Zip _____ Sex: _____

_____ Home Phone: (_____)_____

_____ Work Phone: (_____)_____

Employer: _ _ _ _____

Addr 1: _____

Addr 2: _____

City, St, Zip: _____

Emergency Cont: _____ Patient's Relationship to Emergency Cont:: _____

Addr 1; _____ Home Phone: _____

Addr 2 _____ Work Phone: _____

City, St, Zip: _____

How did you hear of our practice? ❑Billboard ❑Brochure ❑Health Fair ❑Health Plan ❑Internet ❑Jeff NOW* ❑Mass Mailing
❑Newspaper/Mag. ❑Ongoing Care ❑Other ❑Patient ❑Phone Bk Phys. Off/Er ❑Relative ❑Radio ❑TV ❑Word of Mouth

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A separate form is required for workers'' compensation,automobile liability, or legal service.

PRIMARY CARRIER_____

Address _____ Telephone: (____) _____

Group/Plan #: _____ ID/Cert #:: _____

Subscriber's Name:_____ Subscriber's DOB:_____

Relationship to Patient: _____ Effective Date: _____

PRIMARY CARRIER _____

Address::_____ Telephone: (_____) _____

Group/Plan #: _____ ID/Cert #:: _____

Subscriber's Name:_____ Subscriber's DOB: _____

Relationship to Patient: _____ Effective Date: _____

Primary Care Physician / Referring Physician

PCP: _____ Refer. Phys. (if different): _____

Addr _____ Addr

City, St, Zip _____ City, St, Zip _____

Telephone:_____ telephone: _____

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Thomas Jefferson University Hospital
Jefferson Health Systems

Patient Signature on File Form

Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to _____ and/or to the individual Attending Physician, for any services furnished to me by that 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 the benefits payable for the related services. I permit a copy of this authorization to be used in place of the origin, and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed? .....❑ Y ❑ N
Do you or your spouse have other insurance? .....❑ Y ❑ N
Are you disabled or have end stage renal disease ❑ Y ❑ N
Is illness/injury the result of an auto accident? .....❑ Y ❑ N
Old illness/injury occur at work? .....❑ Y ❑ N
Has treatment been authorized by the V.A.? .....❑ Y ❑ N
Are you covered under the Black Lung Program.....❑ Y ❑ N
Is there a Medigap coverage secondary to Medicare .....❑ Y ❑ N
Is there insurance coverage primary to Medicare .....❑ Y ❑ N
Is there employer supplemental coverage secondary to Medicare? .....❑ Y ❑ N

Medigap (Medicare Secondary Insurance)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to _____ for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to (Name or Medigap Coverage) any information needed to determine these benefits payable for related services.

Pennsylvania Medical Assistance

I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements. or documents, or concealment of material may be prosecuted under applicable Federal and Sate laws.

Commercial

Assignment of Insurance Benefits

I hereby authorize payment directly to_____ for medical benefits including any major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this agreement, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy.
I permit a copy of this authorization to be used in place of the original.

General

Release of Information

_____ may disclose any or parts of my clinical records to my insurance company or companies, or, in the case of workers' compensation claims, to my past or present employer(s), for purposes of satisfying charges billed by Jefferson and/or its physicians. This authorization does not cover requests from other parties seeking information regarding my account.

Guarantee of Account

For and in consideration of services rendered by _____ to the below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills.

The undersigned certifies that each has read and understands the above terms and conditions.

X _____
Patient Date

X _____
Patient's Agent Representative and Guarantor Signature Date

Please give your insurance card to the receptionist for copying.