Patient Registration Form

Hamilton Psychiatric Services PA.
1 Nami Lane Suite 9. Hamilton, NJ 08619-1251

LAST NAME	FIRST NAME	MIDDLE INITIAL	Age
ADDRESS			
ZIP CODE	CITY	STATE	E MAIL ADDRESS
PRIMARY PHONE	SECONDARY PHONE	OTHER PHONE	DRIVER LICENSE NUMBER
DATE OF BIRTH	SEX ☐ MALE ☐ FEMALE	SOCIAL SECURITY NUMBER	MARITAL STATUS (CHECK ONE) ☐ M ☐ S ☐ W ☐ D
REASON FOR VISIT		REFERRING DOCTOR	

Employer

NAME ADDRESS					
ZIP CODE	CITY	STATE	PHONE	EXT	PHONE DIRECT

Person Responsible for Payment

LAST NAME	FIRST NAME		Middle Initial	
ADDRESS				
ZIP CODE	CITY	STATE	E MAIL ADDRESS	
HOME PHONE	CELL PHONE	FAX	OTHER PHONE	DRIVER LICENSE NUMBER
DATE OF BIRTH	SEX ☐ MALE ☐ FEMALE	SOCIAL SECURITY NUMBER	MARITAL STATUS (CIRCLE ONE) ☐ M ☐ S ☐ W ☐ D	

Check Appropriate Box

☐ ILLNESS	☐ AUTO ACCIDENT	☐ WORK Related	☐ OTHERS	DATE OF ACCIDENT:

Primary Insurance

NAME			PRIMARY INSURANCE ADDRESS		
CITY	STATE	ZIP CODE	POLICY NUMBER	SUBSCRIBER	RELATIONSHIP TO INSURED (CHECK ONE) ☐ SELF ☐ SPOUSE ☐ CHILD

Secondary Insurance

NAME			SECONDARY INSURANCE ADDRESS		
CITY	STATE	ZIP CODE	POLICY NUMBER	SUBSCRIBER	RELATIONSHIP TO INSURED (CHECK ONE) ☐ SELF ☐ SPOUSE ☐ CHILD

Emergency Contact

NAME	Address	Phone
RELATIONSHIP ☐ Friend ☐ SPOUSE ☐ CHILD		
NAME	Address	Phone
RELATIONSHIP ☐ Friend ☐ SPOUSE ☐ CHILD		

PLEASE NOTE: INSURANCE POLICIES ARE CONTRACTS BETWEEN YOU, THE SUBSCRIBER, AND THE INSURANCE COMPANY. THE DOCTOR CAN IN NO WAY ALTER THE CONTRACT NOR GUARANTEE PAYMENTS BY THE INSURANCE COMPANY.

I UNDERSTAND THAT THE BALANCE AND PAYMENT OF MY ACCOUNT ARE MY RESPONSIBILITIES.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process the insurance claim. I also request payment of benefits to be send to party who accept assignment.

AUTHORIZED SIGNATURE: ____ DATE: __________________________

PATIENT NAME (PLEASE PRINT): ____

SANI