Excelcare Medical Associates, PA

Clenton Coleman, MD
222 Cedar Lane
Teaneck, NJ 07666

PATIENT NAME:_____
FIRST NAME MIDDLE INITIAL LAST NAME

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

SEX: M ☐ F ☐ DO YOU RESIDE IN A SKILLED NURSING FACILITY? YES ☐ NO ☐ EMAIL ADDRESS:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____

DOB:_____ SS#:_____ MARITAL STATUS: S ☐ M ☐ D ☐ W ☐ NAME OF SPOUSE:_____

EMPLOYER:_____ EMPLOYER ADDRESS:_____

EMERGENCY INFORMATION

CONTACT PERSON_____ RELATIONSHIP TO PATIENT:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____

REFERRING PHYSICIAN/FRIEND:_____

IF FULL-TIME STUDENT, INDICATE SCHOOL CURRENTLY ATTENDING:_____

PRIMARY INSURANCE:_____

POLICY #:_____ GROUP #:_____

ADDRESS:_____ EFFECTIVE DATE:_____

RELATIONSHIP TO INSURED:_____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____ SS#_____ DOB_____

SECONDARY INSURANCE:_____

POLICY #:_____ GROUP #:_____

ADDRESS:_____ EFFECTIVE DATE:_____

RELATIONSHIP TO INSURED:_____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____ SS#_____ DOB_____

ASSIGNMENT OF BENEFITS: MY SIGNATURE BELOW INDICATES MY CONSENT FOR TREATMENT AND CONFIRMS MY UNDERSTANDING THAT ALL NON-COVERED ITEMS, CO-PAYMENTS AND DEDUCTIBLES ARE MY RESPONSIBILITY AND THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIMS THAT WAS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY INSURANCE COMPANY. IF I AM UNCOVERED BY ANY INSURANCE, I AGREE TO PAY THE SELF-PAY FEE FOR THE SERVICES I RECEIVE.

SIGNED:_____ DATE:_____

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND THE CENTER FOR MEDICARE AND MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNED:_____ DATE:_____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PROVIDER OF SERVICE AND (OR) SUPPLIER FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER OF SERVICE AND (OR) SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICARE INFORMATION ABOUT ME TO RELEASE TO:

MEDIGAP INSURANCE:_____ HIC#_____

ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED:_____ DATE:_____