UNIVERSITY HOSPITAL
Newark, New Jersey

REGISTRATION FORM

PLEASE COMPLETE FRONT AND BACK OF FORM

(Please Print)

Today's date:			PCP:	
PATIENT INFORMATION				
Patient's last name: First: Middle:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status
Birth date: / /	SS no.:		Age:	Sex: ❑ M ❑ F
Street address:		Home phone no.: ( ) Cell Phone no.: ( )		
P.O. box:	City:		State:	ZIP Code:
Occupation:	Employer:			Employer phone no.: ( )
Referred to clinic by:				
IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):				**Relationship to patient:**
Home phone no.: ( )		Cell no.: ( )		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician and or the facility. I understand that I am financially responsible for any balance. I also authorize University Hospital or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PLEASE COMPLETE BACK OF FORM

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist. If patient is a minor, the parent or guardian's information must be entered here.)					
Person responsible for bill:				Birth date: / /	
Address (if different):			Home phone no.: ( )		
Is this patient covered by insurance?	❑ Yes	❑ No			
Please indicate primary insurance					
PRIMARY INSURANCE					
Subscriber's name:	Subscriber's S.S. no.:		DOB: / /		
Group no.:	Policy no.:		Co-payment: $		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):					
Subscriber's name:	Subscriber's S.S. no.:		DOB: / /		
Policy no.:			Group no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IF YOU WERE INJURED DUE TO AN ACCIDENT, YOU MUST COMPLETE THIS SECTION AND FURNISH DOCUMENTATION REGARDING PAYMENT FOR SERVICES RENDERED.		
Date of accident:	Place:	
Insurance Carrier:	Phone #: ( )	
Policy Number:	Claim #:	
Billing Address:	City/State:	Zip:
Adjusters Name :	Phone # ( )	Ext.
Attorney's Name:	Phone # ( )	Ext.
Address:	City/State:	Zip: