DOCTORS MEDI CENTER

835 Roosevelt Ave
Carteret, NJ 07008

T: 732-969-2240 F: 732-969-2152

PATIENT REGISTRATION

Thank you for choosing Doctors Medi Center to take care of you and your loved ones. Please fill out this form to the best of your ability and return it to the front desk along with a photo ID and insurance card (if applicable).

PATIENT INFORMATION

Last Name	First Name	Middle Initial
Date of Birth / /	Social Security # - -	Male Female

CONTACT INFORMATION

Mailing Address	Home Phone
Zip	Cell Phone
City State	Email Address
Preferred Method of Contact Home Cell Email Letter	

PRIMARY INSURANCE INFORMATION

Please give your photo ID and insurance card(s) (if applicable) to the front desk

Whos is the primary cardholder for this policy?	
Relationship to Patient	Insurance Company
Guarantor DOB	ID #
Guarantor Phone #	Group #
Address *(If different from patient)*	

SECONDARY INSURANCE

Whos is the primary cardholder for this policy?	
Relationship to Patient	Insurance Company
Guarantor DOB	ID #
Guarantor Phone #	Group #
Address *(If different from patient)*	

HOW DID YOU HEAR ABOUT US?

Friend Family Hospital/Dr Refferal Insurance Directory

Work Social Media Our Website

I declare under penalty of perjury that I have examined all information contained herein, and to the best of my knowdlege and belief, they are correct and true. I, as the guarantor, am responsible for providing any/all changes in coverage and Primary Care Physician selection. Any person who commits insurance fraud, upon conviction, shall be guilty of a felony.

I authorize my insurance benefits to be paid directly to Doctors Medi Center. I also understand that I am financially responsible for any balance left and pledge to pay any amount owed within **three (3) months** of my visit.

Patient_____ Guarantor_____ Date_____