RELIANCE
MEDICAL GROUP

Atlantic County
Cape May County
Monmouth County

☐ Reliance Galloway
331 Jimmie Leeds Rd.
Galloway, NJ 08205

☐ Reliance Ventnor Ave
4401 Ventnor Ave
Atlantic City, NJ 08401

☐ Reliance Atlantic City
1325 Baltic Ave
Atlantic City, NJ 08401

☐ Reliance Absecon Island
53 White Horse Pike
Galloway, NJ 08205

☐ Reliance Somers Point
155 Medical center Way
Somers Point, NJ 08244

☐ Reliance Pleasantville
850 main Street
Pleasantville, NJ 08232

☐ Reliance Pleas.Peds
22 N. Franklin Blvd.
Pleasantville, NJ 08232

☐ Reliance Marmora IM
60 Tuckahoe Road
Marmora, NJ 08223

☐ Reliance Mays Landing
1305 Route 50 South Mays
Landing, NJ 08330

☐ Reliance Walk-In Center
4013 U.S.9 North Suite 1N
Howell, NJ 07731

☐ Reliance Howell IM
4630 U.S.9 South
Howell, NJ 07731

☐ Reliance
(RESERVED)

☐ Reliance
(RESERVED)

Date/Fecha:

____/_____/_____

PLEASE NOTE:

You must print your Name, DOB, and SS# **exactly** how it appears on your insurance card.
All Medicare patients: Please only write your name as it's spelled on your SS card.
This will eliminate insurance denials which can cause insured patients to become fully responsible for payments.

PATIENT INFORMATION:

Patient Name/Nombre del Paciente:_____ **Gender: M__F__**

Date of Birth/Fecha de Nacimiento:___/___/____ **SS#** _____

Address/Direccion: _____

City/Ciudad:_____ **State**/Estado:_____ **Zip Code:**_____

Phone/Telefono:_____ **Cell**/Cellular:_____ **Email:** _____

Employer Name/Nombre del Empleador:_____

If patient is under 18, please complete the following information:

Mother's Name/Nombre de Madre:_____ **DOB:** ___/___/____

Father's Name/Nombre de Padre:_____ **DOB:** ___/___/____

Legal Guardian:_____**(If different from parents**/Si es diferente de los padres)

Relationship to Patient/ Relacion al Paciente:_____
Emergency Contact/Contacto de Emedencia:_____
Phone/Telefono:_____

For OB/GYN patients ONLY:
Please, check this box if you cho☐to not disclose parent information.
HIPAA Privacy Rule and Adolescents.

RELEASE OF MEDICAL INFORMATION:

Reliance Medical Group, its Physicians and Staff are authorized to share my information and provide copies of my entire medical record; *excluding psychotherapy notes,* but including all oral and written reports, including confidential HIV and AIDS related information to the following person (s) – INITIAL ALL THAT APPLY:

____ Spouse ____ Parents ____Power of Attorney ____ Patient's Children _____Other (Specify)

This assignment remains in effect until revoked by me in writing.

Signature/Firma:_____ **Date/Fecha:** ____/____/_____

COMMUNICATION (Initial all that apply): _____Cell phone; _____Home Phone; _____Work Phone; _____Email; _____ Permission to leave a detailed message; _____Permission to leave a call back # ONLY

Translator Needed at Appointment?/Traductor Necesita?: **Yes/Si** **No**

INSURANCE INFORMATION:

PRIMARY Insurance Name/Nombre de Seguros:_____

ID #_____ **Group #**_____ **PCP:**_____

Subscriber Name on Card/Nombre de Subscriptor: _____
Date of Birth/Fecha de Nacimiento: ____/____/_____ **SS#:**_____

SECONDARY Insurance Name/Nombre de Seguros:_____

ID #_____ **Group #**_____ **PCP:**_____

Subscriber Name on Card/Nombre de Subscriptor: _____
Date of Birth/Fecha de Nacimiento: ____/____/_____ **SS#:**_____

TERTIARY Insurance Name/Nombre de Seguros:_____

ID #_____ **Group #**_____ **PCP:**_____

Subscriber Name on Card/Nombre de Subscriptor: _____
Date of Birth/Fecha de Nacimiento: ____/____/_____ **SS#:**_____

PREFERRED PHARMACY:

Pharmacy name/Nombre de Farmicia:_____ **Where?**/Donde?_____

Phone/Telefono: _____

FAMILY/FAMILIA:

Do you have any other family members currently being seen at Reliance Medical Group (any office location)?/Tiene algun miembro de la familia que actualmente se observa en cualquier ubicacion confianza Consultorio medico de group?

☐ **Yes/Si** ☐ **No**

Please list/Por favor lista: _____ **Relationship**/Relacion: _____

_____ _____

_____ _____

_____ _____

I give consent for treatment to Reliance Medical Group provider(s) and staff. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand that I am financially responsible for ALL charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

I authorize the use of my signature on all insurance submissions.

Doy mi consentimiento para el tratamiento a Reliance Medical proveedor Grupos y personal. Yo acepto que el psgo es debido en el momento del tratamiento, a menosque se tomen otras medidas. Entiendo que soy financieramente responsible de todos los cargos sean o no pagados por el seguro. Por la presente autorizo al doctor a divulger toda la informacion necesaria para asegurar el pago de las prestaciones.

Yo autorizo el uso de mi firma en todas las sumisiones del seguro.

Date/Fecha: ____/____/_____ **Patient/Guardian Signature**/Paciente/Tutor Firma:_____