

# ADVANCED GASTROENTEROLOGY OF BERGEN COUNTY, P.A.

140 Sylvan Ave., Suite 101A-101B  
Englewood Cliffs, New Jersey 07632  
(201) 945-6564

(Please Print)

## REGISTRATION FORM

E-MAIL

PATIENT INFORMATION					
Patient's Last Name		First	Middle	Mr. Mrs. Miss Ms.	Martial Status (circle one): <small>Single / Married / Divorced / Separated / Widow</small>
Birth Date	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security#:		Home Phone#:
Street Address:				Cell Phone#:	
P.O. Box	City			State/Zip	
Occupation		Employer Name		Employer Phone#	
Employer Address					
Pharmacy Name				Pharmacy Phone#	
Do you have a prescription plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Other family members seen here:	
Primary Care Doctor:				Primary Doctor's Phone No:	
Referring Doctor (If different from Primary Care Doctor):					

INSURANCE INFORMATION			
<b>(Please give your insurance card, referral (if needed), and co-pay to the receptionist)</b>			
Person responsible for bill:	Birth Date	Address (if different):	Home Phone#:
Occupation	Employer Name		Employer Phone#
Employer Address			

PRIMARY INSURANCE					
Subscriber's Name	Subscriber's SS#	Subscriber's Birth Date	Group#	Policy#	Co-Payment:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

SECONDARY INSURANCE					
Subscriber's Name	Subscriber's SS#	Subscriber's Birth Date	Group#	Policy#	Co-Payment:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address)		Relationship to Patient	Home Phone#:
			Work Phone#:

**NO SHOW FEE:** We require 24 hour notice if you need to change or cancel an appointment. A \$50 fee will be charged for a doctor's appointment if you fail to notify us. A \$150 fee will be charged for an endoscopy appointment if you fail to notify us.

**CO-PAYMENT:** Your copay is due and payable when you arrive for your appointment. It is an added expense to the practice if we have to bill you. A \$15 fee will be charged if you do not pay your copay in full at your visit.

I request payment of authorized Medicare benefits be made either to me or on my behalf to SCHERL, CHESSLER, ZINGLER, SPINNELL & MEININGER, M.D., P.A. for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Patient/Guardian Print Name		
Patient Guardian Signature		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 my Medigap Insurance: \_\_\_\_\_ any information needed to determine these benefits payable for related services.

Patient/Guardian Print Name		HIC#:
Patient Guardian Signature		Date

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize SCHERL, CHESSLER, ZINGLER, SPINNELL & MEININGER, M.D., P.A. or Insurance company to release any information required to process my claims. I also understand that if I did not give the correct insurance information I will be 100% responsible for all balances left unpaid.

Patient/Guardian Print Name		
Patient Guardian Signature		Date