SOUTH CUMBERLAND MEDICAL ASSOCIATES

215 Back Neck Road - Bridgeton NJ 08302
856-451-4414 Fax: 856-451-2051
southcumberlandmedical.com
Christopher Ballas, MD, MBE Lori Talbot, MD

Patient History Information

Please print legibly. This form will remain in your medical record and all information will be kept confidential

Part 1 - Personal Information - Everyone Fill Out

important - please enter name **exactly** as it appears on your driver's license

name	gender	social security #	marital status	date-of-birth month-day-year

address street, city, state, zip	home phone

cell phone	fax number	e-mail address	occupation	employer

Emergency Contact Person/ Relationship	Can your PHI be shared with this person?	contact's phone number

pharmacy address street, city, state, zip	pharmacy phone number

Subscriber Information: If you are insured through your work, Medicare or a policy you have purchased, you are the policy subscriber. If you are insured under your spouse or parent's policy, your spouse or parent is the subscriber

subscriber's name	subscriber's social security #	subscriber's date-of-birth month-day-year

Part 2 - Fill this out if you are insured by your employer

employer's address street, city, state, zip	phone

Part 3 - Fill this out if you are insured by your parent

parent's name	parent's social security #	parent's date-of-birth month-day-year	parent's employer

employer's address street, city, state, zip	parent's phone

Part 4 - Fill this out if you are insured by your spouse

spouse's name	spouse's social security #	spouse's date-of-birth month-day-year	spouse's employer

spouse's employer address street, city, state, zip	spouse's employer phone

Note: All charges, including co-payments and deductibles, are expected to be paid at the time of service, regardless of your insurance coverage.

Signature: ______________________________ Date: ______________

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Patient Name: ______________________________ Date: __________
First, MI, Last

Date of Birth: __________ ❑Male ❑Female Age: ______ SS# __________

Address: __________ City: __________ State: ______ Zip: ______

Home Phone: __________ Cell: __________

Business Phone: __________ Email: __________

* By supplying my email, I authorize SCMA to send me emails about the practice; I understand I can unsubscribe at any time.

Pharmacy: __________ Address: __________ City: __________

Employer Name: __________

Occupation: __________

Employment status: ❑FT; ❑Part-time; ❑Self-Employed; ❑Unemployed; ❑FT Student; ❑Part-time Student; ❑Retired

Race*: ❑Asian; ❑Black/African American; ❑Caucasian; ❑Hispanic; ❑Other: ______________________

Ethnicity*: ❑Hispanic/Latino; ❑NOT Hispanic/Latino

Preferred Language*: ❑English; ❑Spanish

***Please note these questions are asked to comply with US Government requirements.**

Emergency Contact Information

I agree that my Protected Health Information (PHI) may be shared with the following people:

Name: ______________________________ Relationship: ______________________

Phone: ______________________________ PHI: ❑Yes ❑NO

Name: ______________________________ Relationship: ______________________

Phone: ______________________________ PHI: ❑Yes ❑NO

Subscriber of Insurance Information:

Name: ______________________________ Relationship to Patient: ______________

Address (if different from above): ______________________________

SCMA is required by law to maintain the privacy and security of your protected health information (PHI). We are also required to provide you with our notice of privacy practices which describes our legal responsibilities and your rights regarding the use and disclosure of your PHI. Your signature below is an acknowledgement that you have received our Notice of Privacy Practices (Please ask for your copy).

I authorize (1) The use of this form whether original or copy, to be used on my insurance and/or Medicare submissions; 2) Release of information to all my insurance companies including Medicare; 3) Payment directly to SCMA from Medicare, all insurance companies, and/or third party payers; 4) SCMA to act as my agent in helping me obtain payment from my insurance company and/or Medicare. I understand that I am responsible for my bill. Should my account be referred to a Collections Agency, I understand that I am responsible for the 33% Collections Fee. I request that payment of authorized Medicare benefits be made on my behalf to SCMA. I give permission SCMA to fill out the Medicare form on my behalf. I understand that Medicare and most insurance companies do not cover medical services that are deemed cosmetic in mature. This includes, but is not limited to procedures such as removal of skin tags, warts, cryosurgery, etc.

Signature:______________________________ Printed Name: ______________________