GOLDSON MEDICAL ASSOCIATES, LLC

20 Valley Street, Suite 320 · South Orange, NJ 07079
Phone: 973-313-1113 · Web Address: www.goldson-medical.yourmd.com

DEBRA GOLDSON-PROPHETE, MD

PATIENT INFORMATION

Name: (First) (Last) (Middle)

Date of Birth: Age: Sex: □ Male □ Female

SS #: - - Marital Status: □ Married □ Single □ Widowed □ Divorced

Street Address: (City/State) (Zip Code)

Home Phone#: Work #: Cell #:

Employer name: Employer Phone#:

Employer Address:

Pharmacy Name: Pharmacy Phone #:

Emergency Contact: (Name) (Phone #) (Relation)

How did you hear of us? □Friend □Ad □Web □Doctor_____ □Other_____

GUARANTOR/RESPONSIBLE PARTY (Person responsible for bill) If same as above, write "

Name: SS#: Date of Birth:

Relation: Phone#:

Address:

INSURANCE INFORMATION

Please complete all insurance details to ensure correct billing information.

Insurance Name: Phone #:

Address: (City/State) (Zip Code)

Subscriber: Subscriber DOB: Relation:

Policy/ID #: Claim #:

Plan/Group #: Group Name:

Insurance Name: Phone #:

Address: (City/State) (Zip Code)

Subscriber: Subscriber DOB: Relation:

Policy/ID #: Claim #:

Plan/Group #: Group Name:

RELEASE AND ASSIGNMENT:

I, the undersigned, certify that I, or any dependent, have insurance coverage with the above mentioned and I have assigned directly to Goldson Medical Associates, LLC my insurance benefits. For anything otherwise, I am responsible for payment of services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Goldson Medical Associates, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____