



Thomas  
Jefferson  
University

Jefferson  
University  
Physicians

Account No.	Entered Date
Reg. By	Office Site

# JUP Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.**

Today's Date: \_\_\_\_\_

Patient Name: _____ Last Name	Social Security Number: _____
First Name: _____ MI	Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Other Name: _____	Race: ( <b>Response is not mandatory. Data is used for statistical reporting.</b> )
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other	<input type="checkbox"/> African American <input type="checkbox"/> Asian/Oriental <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Addr1: _____	Home Phone: (_____) _____
Addr2: _____	Other Phone: (_____) _____
City, State, Zip: _____	
Home E-mail: _____	Home Fax: (_____) _____
Employer: _____	Emp Status: <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time
Addr1: _____	<input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker
Addr2: _____	<input type="checkbox"/> Student <input type="checkbox"/> Active Military <input type="checkbox"/> Self-Employed <input type="checkbox"/> Other _____
City, St, Zip: _____	Work Phone (_____) _____

**Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)**

Guarantor: _____	Patient's Relationship to Guarantor: _____
Addr1: _____	Social Security Number: _____
Addr2: _____	Date of Birth: _____
City, St, Zip: _____	Sex: _____
_____	Home Phone: (_____) _____
_____	Work Phone: (_____) _____
Employer: _____	
Addr1: _____	
Addr2: _____	
City, St, Zip: _____	

Emerg Cont: _____	Patient's Relationship to Emerg Cont: _____
Addr1: _____	Home Phone: (_____) _____
Addr2: _____	Work Phone: (_____) _____
City, St, Zip: _____	

How did you hear of our practice?  Billboard  Brochure  Health Fair  Health Plan  Internet  Jeff NOW®  Mass Mailing  
 Newspaper/Mag.  Ongoing Care  Other  Patient  Phone Bk  Phys. Off./ER  Relative  Radio  TV  Word of Mouth

### Insurance Information

**A separate form is required for workers' compensation, automobile liability, or legal services.**

PRIMARY CARRIER: _____	
Address: _____	Telephone #: (_____) _____
Group/Plan #: _____	ID/Cert #: _____
Subscriber's Name: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Effective Date: _____
SECONDARY CARRIER: _____	
Address: _____	Telephone #: (_____) _____
Group/Plan #: _____	ID/Cert #: _____
Subscriber's Name: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Effective Date: _____

### Primary Care Physician / Referring Physician

PCP: _____	Refer. Phys. (if different): _____
Addr: _____	Addr: _____
City, St, Zip: _____	City, St, Zip: _____
Telephone #: _____	Telephone #: _____



# JUP Patient Signature on File Form

## Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jefferson University Physicians and/or to the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

**In order to comply with Medicare regulations, please answer the following questions:**

- |   |  |
|---|--|
| Are you or your spouse employed?..... <input type="checkbox"/> Y <input type="checkbox"/> N                   | Has treatment been authorized by the V.A.? ..... <input type="checkbox"/> Y <input type="checkbox"/> N                   |
| Do you or your spouse have other insurance? ..... <input type="checkbox"/> Y <input type="checkbox"/> N       | Are you covered under the Black Lung Program? ..... <input type="checkbox"/> Y <input type="checkbox"/> N                |
| Are you disabled or have end stage renal disease? .. <input type="checkbox"/> Y <input type="checkbox"/> N    | Is there Medigap coverage secondary to Medicare? .... <input type="checkbox"/> Y <input type="checkbox"/> N              |
| Is illness/injury the result of an auto accident? ..... <input type="checkbox"/> Y <input type="checkbox"/> N | Is there insurance coverage primary to Medicare?..... <input type="checkbox"/> Y <input type="checkbox"/> N              |
| Did illness/injury occur at work? ..... <input type="checkbox"/> Y <input type="checkbox"/> N                 | Is there employer supplemental coverage secondary.... <input type="checkbox"/> Y <input type="checkbox"/> N to Medicare? |

## Medigap (Medicare Secondary Insurance)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Jefferson University Physicians for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to my Medigap Coverage any information needed to determine these benefits payable for related services.

## Pennsylvania Medical Assistance

I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

## Commercial

### Assignment of Insurance Benefits

I hereby authorize payment directly to Jefferson University Physicians for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this agreement, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

## General

### Release of Information

I hereby authorize Jefferson University Physicians to disclose to my insurance company(s) copies of my medical records(s) to obtain payment for services or as part of a post-payment review of medical services, or in the case of Workers Compensation claims, to my present or past employer(s). Additionally, I authorize Jefferson University Physicians to release copies of my medical record(s) to other health care providers serving as consultants to my physician, including referrals for treatment. I recognize that the information disclosed may be protected by federal and/or state law, and I specifically consent to disclose of such information. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it.

### Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for purposes of patient identification.

### Financial Agreement

In consideration of the services rendered to the below named patient, the undersigned agrees to pay Jefferson University Physicians in accordance with its regular charges and terms and, if this account is referred to an attorney or agency for collection, to pay attorney(s) fees, court costs, and collection expenses. I also agree to be responsible for charges not covered by insurance. I understand that my obligation to pay Jefferson University Physicians may not be deferred for any reason, including pending legal action against other parties, to recover medical costs.

**The undersigned certifies that each has read and understands the above terms and conditions.**

X \_\_\_\_\_  
Patient Signature Date

X \_\_\_\_\_  
Patient's Agent Representative and Guarantor Signature Date

**\*Please give your insurance card to the receptionist for copying.**