ROBERT J., MARO, M.D., P.A.
27 COVERED BRIDGE ROAD
CHERRY HILL, NJ 08034
856-429-2224

Account No: _____ **Today's Date:** ____/____/_____

PATIENT INFORMATION: ☐ **New Patient** ☐ **Name Change** ☐ **Address Change** ☐ **Insurance Change**
THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name:_____ **Date of Birth:**_____/_____/_____
Last First M.I.

Mailing Address:_____
City State Zip Code

Social Security #:_____ **Sex:** ☐ **Male** ☐ **Female**

Home Phone(**)**_____ **Work Phone:(** **)**_____ **Cell Phone: (** **)**_____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**
RESPONSIBLE PARTY (if different from patient)

Name: _____ **Date of Birth:** _____/_____/_____
Last First M.I.

Mailing Address:_____
City State Zip Code

Emergency Contact Person:_____ **Relation:**_____**Phone: (** **)**_____

Person Authorized to Receive Medical Information:_____
Name Relation Phone No.

INSURANCE COVERAGE- <u>PRIMARY:</u>
Insurance Co. Name:_____ **Phone:(** **)**_____

Address of Claim Center:_____
City State Zip Code

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: _____/_____/_____ **SS#**_____ **Sex:** ☐ **Male** ☐ **Female**

Policy #:_____ **Group Name or #:**_____

Employer Name:_____ **If patient is child, check relationship:** ☐**Mother** ☐**Father** ☐**Other**

INSURANCE COVERAGE- <u>SECONDARY:</u>
Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth:_____/_____/_____ **SS#:**_____ **Sex:** ☐ **Male** ☐ **Female**

Policy #: _____**Group Name or #:**_____

Employer Name:_____ **If patient is child, check relation:** ☐ **Mother** ☐ **Father** ☐ **Other**

I authorize the physician group Robert J. Maro, M.D., P.A. and his/her associates and partners to treat me. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Robert J. Maro, M.D., P.A. for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Signature:_____ **Date:**_____