Dr. Wendy R. Hurst, MD, LLC

370 Grand Avenue, Suite 202
Englewood, New Jersey 07631
Phone: 201-894-9599 Fax: 201-894-9192

PATIENT INFORMATION

LAST NAME ______________________ FIRST NAME ______________________ MI _____

DATE OF BIRTH ______________________ SS# ______________________

PLACE OF BIRTH ______________________ MARITAL STATUS ______________________

RACE _______________ ***ETHNICITY*** _______________ ***PREFERRED LANGUAGE*** _______________

ADDRESS ______________________CITY______________ST______ZIP__________

HOME PHONE # ______________________ CELL # ______________________

EMAIL ______________________ CAN WE LEAVE MESSAGE ON MACHINE? Y / N

EMPLOYER ______________________ WORK PHONE # ______________________

SIGNIFICANT OTHER'S NAME ______________________ CELL # ______________________

EMERGENCY CONTACT ______________________

EMERGENCY PHONE # ______________________ RELATIONSHIP TO PATIENT ______________________

FAMILY DOCTOR ______________________ PHONE # ______________________

Who May We Thank For Referring You to Our Office ______________________

Pharmacy Address: ______________________

______________________ Phone: ______________________

INSURANCE POLICY HOLDER INFORMATION:

LAST NAME ______________________ FIRST NAME ______________________ MI ____
DATE OF BIRTH ________/________/________ SS# ______________ PHONE # ______________
RELATIONSHIP TO PATIENT: ______________________

Copies of All Current Insurance Cards and Driver's License

Medical Services Contract, Insurance Authorization and Assignment of Benefits

All professional services rendered are the responsibility of the patient and/or guarantor. All applicable insurance will be filed on your behalf for payment. The patient or responsible party is responsible for payment of all co-pays at the time of service as well as non-covered charges and charges denied by insurance for any reason, including charges denied for non-compliance of referral rules or timely filing due to incorrect insurance information, regardless of insurance coverage. I hereby authorize Wendy R. Hurst, MD, LLC to furnish information to insurance carriers concerning my illness and treatment and hereby assign to the treating physician all payments for medical services rendered to myself or my dependents (as the case may be). I understand that I am responsible for any amount not covered by insurance. Should my account be turned over for collection, I further agree to pay all costs of collection, including attorney fees, in the amount of 33.33% interest of the amount due at the time the account is turned over for collection and all court costs, whether suit is brought or not, in the event that payment for services rendered is not made when billed. I further agree to a service charge of 1.55% per month (18%) per annum on the balance due from the date of this contract.

If patient under the age of 18, I give permission for my child to receive treatment from Dr. Wendy R. Hurst.

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Patient/ Guardian/ Guarantor Signature Date