



New Perspectives Health Care  
 13A Main Street, Suite 7  
 Sparta, New Jersey 07871  
 O)973.726.0355 F)973.726.0255

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

## Registration Form

| Patient's Last Name     | First Name                                | Middle Name        |
|-------------------------|---|--------------------|
|                         |   |                    |
| Male or Female          | Marital Status                            | Date of Birth      |
| male or female          | single/married/divorced/separated/widowed | mo/day/yyyy:       |
| Street address          | City                                      | State and Zip Code |
|                         |   |                    |
| Home phone number       | Cell phone number                         | Work Phone number  |
|                         |   |                    |
| Patient's email address | Social Security #                         | Occupation         |
|                         |   |                    |
| Employer                | Employer's address                        | Employer's phone # |
|                         |   |                    |

## Primary Insurance Information

| Person Responsible for Bill | Subscriber's Name             | Address if different                 |
|-----------------------------|-------------------------------|--------------------------------------|
|                             |                               |                                      |
| Subscriber's Employer       | Subscriber's Employer Address | Patient's relationship to Subscriber |
|                             |                               | Self/Spouse/Child/Other              |
| Primary Insurance Company   | Subscriber's Date of Birth    | Co-payment amount                    |
|                             |                               |                                      |
| Subscriber's ID             | Group #                       | Policy #                             |
|                             |                               |                                      |

### Secondary Insurance Information

| Secondary Insurance | Policy or ID #             | Group #           |
|---------------------|----------------------------|-------------------|
|                     |                            |                   |
| Subscriber's Name   | Subscriber's date of birth | Co-payment amount |
|                     |                            |                   |

### Tertiary Insurance Information

| Tertiary Insurance | Policy or ID #             | Group #           |
|--------------------|----------------------------|-------------------|
|                    |                            |                   |
| Subscriber's Name  | Subscriber's date of birth | Co-payment amount |
|                    |                            |                   |

The information above is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the health care provider. I understand that I am financially responsible for any balance. I also authorize New Perspectives Health Care or insurance company to release any information required while processing my claims.

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient or Guardian

#### How did you hear about us?

- Prior Practice?
- Friends?
- Family members?
- Newspaper?
- Other?