



110 Marter Avenue, Suite 408, Moorestown, NJ 08057
• 856.638.1990 • Fax 856.583.0359
• www.bruneaufamilycare.com

Patient Information Sheet

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Emergency: _____

Cell Phone # _____ E-mail Address: _____

EmployerName: _____ Occupation _____

Marital Status: Married Single Other

SS#: _____ Patient Date of Birth; _____ Sex: M F _____

Referred by: _____

Primary Insurance Information

Insurance Plan Name: _____ Effective Beginning Date: _____

Subscriber Name: _____ Relationship to insured: _____

DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

SS# _____ Sex: M F _____ Employer: _____

Group Name: _____ Group #: _____ Policy #: _____

CoPay Amt: _____

Secondary Insurance Information

Insurance Plan Name: _____ Effective Beginning Date: _____

Subscriber Name: _____ Relationship to insured: _____

DOB: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

SS# _____ Sex: M F _____

Group Name: _____ Group #: _____ Policy #: _____

CoPay Amt: _____

Name: _____ SS#: _____ DOB: _____

Please read and sign authorization below:

1. I hereby authorize direct payment of medical benefits to Bruneau Family Care, P.C. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance company. I certify that the information I have given in applying for payment is correct and I authorize release of all records upon request. A photocopy of these assignments shall be valid as the original.
2. I hereby authorize Bruneau Family Care, P.C. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.
3. I hereby authorize any doctor to release necessary medical records that are requested by the Bruneau Family Care, P.C. office.
4. Co-payments not made at date of service are subject to a five dollar (\$5.00) billing fee.
5. Please note that if for any reason, you are not able to make your appointment, we require notification at least 24 hours in advance. If you are not able to make your appointment for any reason and do not notify us, you will be charged a **\$20.00** fee regardless of your required co-payment.
6. All forms that need to be completed will be subject to a fee of at least **\$10.00** unless done at time of visit. Comprehensive forms/letters may require additional fees. Payment is due at request of service.

Name (print): _____

Signature _____ Date: _____

If relative, state relationship: _____