



BRUNEAU  
FAMILY CARE, P.C.

2963 Marne Highway, Mount Laurel, NJ 08054  
• 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 Divorced Separated Widowed Other

SS#: \_\_\_\_\_ Patient Date of Birth; \_\_\_\_\_ Sex: M F \_\_\_\_\_

Ethnicity:

Hispanic or Latino\_\_

Not Hispanic or Latino\_\_

Unknown\_\_

Race:

American Indian or Alaska Native\_\_

Asian\_\_

Black or African American\_\_

Native Hawaiian or Other Pacific Islander\_\_

White\_\_

Other Race\_\_

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 are due at the time of service.
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. Due to billing rules established by insurance companies, Medical problems discussed during your yearly physical may result in collection of you copay or deductible.
7. 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.
8. All routine laboratory and radiology test results may take up to two weeks to get results, unless ordered stat by our physicians.
9. Insurances requiring a referral must notify the office four days prior to your appointment, unless ordered stat.
10. Please be advised in the event you are 20 minutes late for your appointment you may be asked to reschedule your appointment.
11. Please allow 24 hours for prescriptions to be refilled.
12. Due to the volume of emails the physicians receive, do not email the physicians for appointments, referrals, lab slips or prescription refills

Name (print): \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

If relative, state relationship: \_\_\_\_\_