ADVANCED INTERNAL MEDICINE of NORTH JERSEY, LLC 1777 Hamburg Turnpike, Suite 302, Wayne, NJ 07470
Tel: 973-831-9222, Fax: 973-831-1460
Dr. Zhanna Branovan, MD Dr. Libby Joffe, MD

Please write / print your information very clearly, so that it is legible

Name	*Last:* *First:*	**Date of Birth:**
Address	*No., Street, Apt.* *City:* *State:* *ZIP:*	**Social Security #** **Sex** [ ] Male [ ] Female
Tel. (home)		**Marital Status** [ ] Single [ ] Married [ ] Divorced [ ] Widow
Tel. (cell)		**Employment** [ ] Yes [ ] No [ ] FT student [ ] PT student [ ] Retired
Employer		Occupation:
Work Tel.		

Medical information may be shared with Emergency Contact? [ ] Yes [ ] No

Emergency Contact(s):

Emergency Relationship: [ ] Spouse [ ] Son [ ] Daughter [ ] Friend	**Contact Phone #:**
Pharmacy:	**Pharmacy Phone #:**
Primary Care Physician (PCP):	**Referred (if so) by Dr.:**

PRIMARY INSURANCE	SECONDARY / SUPPLEMENTAL INSURANCE
Please provide your insurance card(s) for copying	
Insurance Name:	Insurance Name:
ID # :	**ID # :**
Group #:	**Group #:**
Policyholder (Subscriber) Name :	Policyholder (Subscriber) Name :
Policyholder (Subscriber) Date of Birth:	Policyholder (Subscriber) Date of Birth:
Relationship to Patient:	Relationship to Patient:
Co-pay (Office visit): **$** Deductible:	**Co-pay** (Office visit): **$** Deductible:

Primary Insurance Plan Type: [ ] HMO [ ] PPO [ ] POS [ ] EPO *Other :*

Release of Medical Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim to my Insurance Carrier for services rendered by the provider, and authorize and direct my Insurance Carrier to issue prompt payment directly to Advanced Internal Medicine of North Jersey. I understand that I am financially responsible for the services deemed non-covered by my Insurance Company. I will be charged standard rate as set forth by Advanced Internal Medicine of North Jersey, LLC. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible under state and Federal Law. I understand that these amounts may include co-payments and deductibles.

* This office is HIPAA compliant. The HIPAA Notice of Privacy has been made available to me *

Date: ____/____/_____ Signed (Patient or Guarantor Signature): ____________________