John P. Sersanti, M.D.

Board Certified in Internal Medicine

Fellow, American College of Physicians

Holiday City Medical Center

3 Plaza Drive, Suite 10

Toms River, NJ 08757

Phone: (732) 797-0477

Fax: (732) 797-0644

New patients, please bring to your first appointment:

1. Current health insurance card/documentation
2. Driver's license or photo ID
3. All medications (not a list) of prescription bottles and supplements/vitamins you are currently self-administering
4. Most recent blood test results (if available)
5. A big smile!

John P. Sersanti, M.D.

PATIENT DEMOGRAPHICS

PATIENT INFORMATION :

E-mail _____

Last _____ First _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

DOB _____ Social Security # _____ Sex _____

Home Phone # _____ Cell# _____ Work# _____

Primary Insurance: _____ Co-Pay _____

Policy Holder's Name: _____ DOB _____ SS# _____

Member ID# _____ Member Phone# _____

Secondary Insurance: _____

Policy Holder's Name: _____

Member ID# _____

DOB _____ SS# _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Local Pharmacy: _____ **Pharmacy Address:** _____

Pharmacy Phone#_____ **Mail Order Pharmacy** _____

(Other than Spouse) Family Emergency Contact **Name** and **Phone** Number

Name _____Relationship _____Phone#_____

Living Will ☐Yes ☐No

Office of John P. Sersanti, M.D.

HIPAA Consent Form

I hereby give my consent to the practice of John P. Sersanti, M.D., to use or disclose my health information to facilitate my medical treatment, obtain payment from insurers, and for healthcare quality review.

I understand I may revoke this consent in the future by making a written request, except for information that has already been used or disclosed.

Please check all:

Medical practice permission to leave detailed medical information on your message system ☐ Yes ☐ No

Medical practice permission to mail medical documentation to your primary residence ☐ Yes ☐ No

Medical practice permission to fax medical documentation to your home ☐ Yes ☐ No

Medical practice permission to provide messages to your emergency contact ☐ Yes ☐ No

If yes, to whom may we discuss/provide medical information?

_____

Patient Signature: _____ Date: _____

Print Full Name: _____

(If signed by patient representative, state relationship) _____

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Assignment of Benefits

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to **Dr. John P. Sersanti, M.D., P.C.** all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent starts on the date signed below and ends when you are no longer our patient.

In the event that your account is unpaid and we need to seek the services of a collection agency, a 30% collection fee will be added to your account.

Signature: _____ **Date:** _____

Print Full Name: _____