

Lifeline Medical Associates LLC

99 Cherry Hill Road
 Parsippany, NJ 07054-4909
 (800) 845-2785

PATIENT INFORMATION

NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS		ETHNICITY
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP		RACE
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)				
ADDRESS				ADDRESS				
CITY, STATE ZIP				CITY, STATE ZIP				
WORK PHONE				WORK PHONE				

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)				SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)			
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY				POLICY#			
NAME OF INSURED				GROUP#			
ADDRESS OF INSURANCE COMPANY				COPAY AMT \$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE		EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY				POLICY#			
NAME OF INSURED		SSN#	BIRTHDATE	GROUP#			
ADDRESS OF INSURANCE COMPANY				COPAY AMT \$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE		EXPIRATION DATE	

I authorize the release of medical information to process the claims for medical benefits and any payment of medical benefits to LMA, LLC.

I agree to pay all costs of collection and attorney's fees associated with collection due to services rendered and performed. I am financially responsible to LMA and its successors and assign any individual it may designate for any balance not covered by insurance.

SIGNATURE OF PATIENT/GUARDIAN _____

DATE _____