ADVANCED INTERNAL MEDICINE OF NORTH JERSEY, LLC **1680 ROUTE 23, SUITE 310, WAYNE, NJ, 07470**
Tel: 973-831-9222 **Fax: 973-831-1460**

Dr. Zhanna Branovan, M.D. **Dr. Libby Joffe, M.D.**

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

Name **Last:** **First:** Middle:			**Date of Birth**
No., Street, Apt. **Address**			**Social Security #**
City: State: ZIP:			**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 ( ) Child ( ) Parent ( ) Friend	**Contact Ph #**
Pharmacy	**Pharmacy Ph#**
Primary Care Physician (PCP)	**Referred (if so) by**

Please provide your insurance card for copying

PRIMARY INSURANCE	SECONDARY/SUPPLEMENTAL INSURANCE
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**
Copay (office visit) $ **Deductible** $	**Copay** (office visit) $ **Deductible** $

Primary Insurance Plan Type ( ) HMO ( ) PPO ( ) POS ( ) EPO Other

Release of Medical Information and Assignment 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) _____