KUBICK KUBICK INC.

PERSONAL HISTORY

Last Name: _____ First Name: _____ MI: _____
DOB: _____ Sex: M F Email: _____
Mailing Address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ SSN: _____
Primary Insurance Company _____ Policy # _____
Secondary Insurance Company _____ Policy # _____
Employment Status: _____
Marital Status: Married Single Divorced Widowed

How did you hear about us? Mail Newspaper TV Online Other
Referred by Friend: _____
Referred by Physician: _____

Emergency Contact: _____ Phone: _____
Relation to Patient: _____
Primary Care Physician: _____ Phone: _____

PLEASE READ CAREFULLY AND SIGN BELOW

I give permission to Kubick & Kubick, Inc. to release information, verbal and written, contained in my medical record and other related information to my insurance company, rehab nurse, case manager, attorney, employer, related health care providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

I have read all the information on this sheet and have completed the above answers, certified this information as true and correct to the best of my knowledge and hereby give Kubick & Kubick, Inc. permission to treat my concerns.

I have read and understand all the above information.

A copy of this signature is as valid as the original. _____ Date: _____

Signature of Parent or Guardian if patient is a minor. _____

393 Millburn Avenue
Millburn, NJ 07041
(973) 467-1690