Corporate Office
228 Lafayette Street
Newark, New Jersey 07105
(973) 789 - 8111

PATIENT INFORMATION FORM

PLEASE PRESENT YOUR CURRENT INSURANCE CARD AND ID FOR PHOTOCOPYING

GENERAL INFORMATION

Last Name: _____ **First Name:** _____

Social Security # _____ **Date of Birth:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:**_____ **Birth Sex:** ___ **Female** ___ **Male**

Home #: _____ **Cell #:**_____

Email: _____ **Primary Language:**_____

Race: (Mark All That Apply)

☐ **Asian** ☐ **Native Hawaiian** ☐ **Other Pacific Islander** ☐ **African American/Black**
☐ **American Indian/Alaska Native** ☐ **European/White** ☐ **Unreported/Refuse To Report**

Ethnicity: **Hispanic or Latino?** ☐ **Yes** ☐ **No** ☐ **Unreported/Refuse To Report**

Emergency Contact: (To Be Contacted **Only** In The Event Of An Emergency)

Name: _____ **Phone:** _____ **Relationship:** _____ **18 or over** ☐ **Yes** ☐ **No**

Name: _____ **Phone:** _____ **Relationship:** _____ **18 or over** ☐ **Yes** ☐ **No**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Do you lack permanent housing? (Are you experiencing Homelessness)? ☐ **Yes** ☐ **No**

If yes, check one: ☐ **Doubling Up** (Living with Friends or Family) ☐ **Homeless Shelter** ☐ **Street**
☐ **Transitional** ☐ **Unknown** (Decline To State) ☐ **Unknown**

Approximate Monthly Household Income?

☐ **Under $1,000** ☐ **$1,000 - $1,500** ☐ **$1,500 - $2,000** ☐ **$2,000 – 2,500** ☐ **$2,500 - $3,000**
☐ **$3000 - $3,500** ☐ **$3,500 - $4,000** ☐ **$4,000 - $4,500** ☐ **$4,500 – 5,000** ☐ **$5,000 - $5,500**
☐ **$5,500 - $6,000** ☐ **Over $6,000**

How many people live in your Home? _____

Patient Name: _____ **Date of Birth:** _____

PRIMARY INSURANCE

Insurance Company: _____ **Member ID:** _____ **Group ID:** _____

Relationship to Insured: ___ **Self** ___ **Spouse** ___ **Child** ___ **Other:** _____

Name of Policy Holder: _____ **Policy Holder Date of Birth:** _____

Policy Holder Address: _____

SECONDARY INSURANCE

Insurance Company: _____ **Member ID:** _____ **Group ID:** _____

Relationship to Insured: ___ **Self** ___ **Spouse** ___ **Child** ___ **Other:** _____

Name of Policy Holder: _____ **Policy Holder Date of Birth:**_____

Policy Holder Address: _____

Pharmacy Services

You and/or your Minor will be enrolled in the Saint James Pharmacy. If you wish to opt out, please put the name, address and telephone number of the pharmacy you wish to use here.

Pharmacy Name: _____ **Phone** #: _____

Address: _____

_____