Bergen Surgical Specialists, P.A.

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Gregory T. Simonian, M.D.
David J. O'Connor, M.D.

Massimo Napolitano, M.D.
Michael Wilderman, M.D.

FIRST_____ M.I. _____ LAST _____

ADDRESS_____

SOCIAL SECURITY # _____ D.O.B. _____

MALE / FEMALE
ASIAN / BLACK / HISPANIC / WHITE

MARRIED / DIVORCED / SINGLE / WIDOWED
LATINO / NOT LATINO

PHONE _____ WORK_____ CELL_____

EMPLOYER _____ PHONE _____

ADDRESS _____

EMERGENCY CONTACT _____PHONE _____

REFERRING DR _____ PHONE _____

FAMILY DR _____PHONE _____

CARDIOLOGIST _____ PHONE _____

PHARMACY _____ PHONE _____

ADDRESS _____

MEDICATIONS _____

_____

_____

INSURANCE INFORMATION

PRIMARY _____ **ID#** _____

SUBSCRIBERS NAME _____ DOB _____

SECONDARY _____ **ID #** _____

SUBSCRIBERS NAME _____ DOB _____

FINANCIAL RESPONSIBILITY/Responsabilidad Financiera

I am aware that my insurance carrier may not cover all parts of the services I have or will receive at Bergen Surgical Specialists, P.A., and that I, the undersigned, do hereby guarantee payment in full to Bergen Surgical Specialists, P.A., of all charges rendered, or any charges exceeding insurance payments received by this office. I am aware that I have the option to seek services performed by Bergen Surgical Specialists, P.A. I have read the foregoing statement and fully understand my rights and obligations related thereto. I know and willing sign this statement.

Que yo sepa mi compañía de seguros no puede cubrir todas las partes de los servicios que tengo o recibirá en Bergen Surgical Specialists, P.A., y que yo, el abajo firmante, por la presente garantiza el pago en su totalidad a Bergen Surgical Specialists, P.A., de todos los cargos rendido, o cualquier cargo que exceda los pagos de seguros recibidas por esta oficina. Soy consciente de que tengo la opción de buscar los servicios realizados por Bergen Surgical Specialists, P.A. He leído la declaración anterior y entiendo completamente mis derechos y obligaciones relacionados con el mismo. Conozco y firmo voluntariamente esta declaración.

SIGNATURE DATE