Soliman Medical Associates

Y .S. Soliman, M.D.
Family Physician

2239 Whitehorse-Mercerville Road,
Hamilton, NJ 08619
609-587-4778
Fax 609-587-1202

H.S. Soliman M.D
Internal Medicine
Infectious Disease

REGISTRATION INFORMATION - Please Print

Patient _____ _____ _____

Last Name First Name Initial

Street Address _____

City _____ State _____ Zip_____

Home Phone # _____ SS#_____ Sex M_____ F_____ Birthdate _____

Spouse/parent or Guardian (if minor) _____

Address _____

Employer _____

Business Address _____

Business Phone _____ Occupation _____

Spouse's Employer _____

Business Address _____

Business Phone _____ Occupation _____

Who is responsible for this account? _____ Relationship to Patient_____

Primary Medical Insurance

Name of Policy Holder _____

Name of Insurance Company _____ Tel#_____

Policy # _____ Group #_____ Subscriber # _____

Secondary Medical Insurance

Name of Policy Holder _____

Name of Insurance Company (if any) _____Tel#_____

Policy # _____ Group #_____ Subscriber # _____

Medicare _____ Medicaid _____ ID# _____

How were you referred to our practice?

Friend/Relative_____ if so, name _____Yellow Pages_____ Hospital Referral_____

Physician_____ if so, name_____ other _____

Newspaper (Name) _____

PHARMACY _____ TELEPHONE #_____

Other Physicians treating you _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually no designed to pay the entire fee. Because insurance companies vary in the amount they will pay for services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have insurer).

IN ORDER TO HELP CONTROL THE COST OF BILLING, WE REQUEST PAYMENT BE MADE FOR ALL OFFICE SERVICES AT THE CONCLUSION OF YOUR VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENDERED.

I authorize the release of my medical records with respect to any claims to the Social Security Administration, Health Care Financing Administration, its intermediaries or any health care claim payer. A photostatic copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE_____ DATE_____