MORRIS SUSSEX FAMILY PRACTICE

694 Route 15 South * Suite 103 * Lake Hopatcong, NJ 07849 * 973-663-8899

NEW PATIENT INTAKE FORM

Today's Date	Patient Last Name, First Name, Middle Initial **LEGAL NAME ONLY**	Date of Birth	Sex	Social Secuity Number
Patient Street Address				
Town		State		Zip Code
Patient Home Number		Patient Work Number (ext)		Patient Cell Number:
Patient's Email:		Living Will: Yes No		Insurance Yes No (self-pay)
Patient Is: Single Widowed Married - Spouse's Name		Patient Relationship to Insured: Self Spouse Child Other		
Ethnicity Asian African-American White Other _____ Declined to Specify				
Any Communication Barrier to medical care? Yes No Describe:				

INSURANCE INFORMATION - THIS SECTION MUST BE COMPLETED

Name of Primary Insurance Carrier		Member ID #	Group #
Address of Primary Insurance Carrier			
Name of Secondary Insurance Carrier		Member ID#	Group #
Insured Name on Secondary Plan		Secondary Insured Date of Birth	
		Medicare ID#	
Medicaid Yes / No	AARP#	Medigap Blue Shield #	
Insurance ID#		Insurance Group ID#	
Preferred Pharmacy / Town		Pharmacy Phone #	
Emergency Contact Name & Phone Number			Relationship

* IF PATIENT IS NOT THE POLICY HOLDER THIS SECTION MUST BE COMPLETED *

Insured Name: Last, First, Middle Initial		Insured Date of Birth/Social Security Number	
Insured Address (if different from above)		Town	State / Zip Code
Insured Home/Cell Phone		Insured Work Phone (ext)	
Insured Employer Name & Address			
Have you had the Covid vaccine? Yes No Dates:			

PLEASE PROVIDE INSURANCE IDENTIFICATION CARD(S)
TO RECEPTIONIST FOR COPY & INCLUSION IN MEDICAL RECORDS

THANK YOU