BOARD CERTIFIED
INTERNAL MEDICINE · FAMILY PRACTICE · BARIATRIC

92 Summit Ave,
Hackensack, NJ 07601

285 Grand Ave, Bld #5
Englewood, NJ 07631

PHONE: (201) 342-0066 • FAX: (201) 342-0079

Ehab Ibrahim, MD
Suhel Ahmed, MD
Marion Bobb-McKoy, MD
Roman Prager, MD
Anthony Kim, MD
John Albanese, PA-C
Cassandra DeSmet, APN

Name____ SS# ______________________________
Last Name First Name Middle Initial

Address____ Email ______________________________

City____State______________Zip ____________________________

Home Phone (____)___________________________________Cell Phone (____)____________________________________

Sex □ M □ F Age____ Birthdate______________ □ Married □ Widowed □ Single □ Minor □ Divorced □ Separated

Patient Employer/School________________________________Occupation____

Employer/School Address______________________________Employer/School Phone (___)_______________________

Whom may we thank for referring you? ____

In case of emergency who should be notified___________________________________Phone (___)__________________

Person Responsible for Account____
Last Name First Name Middle Initial

Relation to Patient __________________Birthdate______________________Soc. Sec. # _______________________

Address (if different from patient's) ____________________________________Phone (____)________________________

City ____State_________Zip ____________________________

Person Responsible Employed by ____________________________________Occupation ____________________________

Business Address ____Business Phone (____)_______________

Insurance Company ____

Cnotract #__________________________________ Group # _____________________ Subscriber # _______________

Is patient covered by additional insurance? □ Yes □ No

Subscriber Name_____________________ Birthdate___________________Relation to Patient __________________

Address (If different from patient's)___________________________________ Phone (___)_______________________

City____ State_______Zip _____________________

Subscriber Employed by ____ Business Phone (___)________________

Insurance Company____ Soc. Sec. #_____________________

Contract #___________________________Group #____________________Subscriber #_____________________

I certify that I, and/or my dependent(s), have insurance coverage with ____and assign directly to
Name of Insurance Company(ies)
Dr.________________________all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information amd may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

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______________________________	______________________________
Signature of Patient, Parent, Guardian or Personal Representative	Date
______________________________	______________________________
Please print name o Patient, Parent, Guardian, or Person Representative	Relationship to Patient