MEDICAL ART CENTER | COVID PATIENT REGISTRATION

950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenternj.com

Name	Last		First		MI
Street					
City		State		Zip	
Home Phone		Email			
Cell Phone		Birthdate	/ /	Age	
Gender	☐ Male ☐ Female	Employer			
Race		Work Phone			
Soc Sec #		☐ Full Time	☐ Part Time	☐ Retired	
Status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Pharmacy			Phone		
Emergency Contact			Phone		
Referred By: Check All That Apply	☐ Friend	☐ Family	☐ Patient		
	☐ Facebook	☐ Doctor		☐ Healthgrades	
	☐ Billboard	☐ TV	☐ Work	☐ Instagram	

Acknowledgment of Receipt of the Notice of Privacy Practices

Name of Patient or Representative **Date**

PATIENT CONFIDENTIALITY (HIPAA)					
Name		**Date of Birth**			
Patient confidentiality is one of our priorities and it is the law (HIPPAA) implemented in 2003. Your privacy is a great concern in our office. Please indicate below with whom and where we may leave a message. When possible we try to confirm appointment as well as leave messages regarding medication, test results, and billing information.					
OUR OFFICE MAY LEAVE A MESSAGE AT					
HOME |Yes| No		**CELL |Yes| No**		**WORK |Yes| No**	
Due to our confidentiality requirements, should a family member, friend, or relative contact our office, please state who we have permission to discuss your condition/results with					
Name		**Relation**			
Name		**Relation**			
Name		**Relation**			
Name		**Relation**			
Please provide your email address to receive office information?					
Please be advised that it is you responsibility to inform us if any changes should be made to the above information. Thank you.					

Date of Last Physical	

CONFIDENTIAL FAMILY MEDICAL HISTORY							
	Alive	Age of Death	Present Health or Cause of Death		Alive	Age of Death	Present Health or Cause of Death
Father				Brothers			
Mother				Sisters			
Spouse				Children			
			Age of Living Children				

CHECK (✓) THE ILLNESSES THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY				
__Diabetes	__Cancer	__Bleeding Tendency	__Kidney Disease	__Tuberculosis
__Heart Disease	__Stroke	__High Blood Pressure	__Depression	__Allergies

MEDICATIONS and dosage you are currently taking, INCLUDE vitamins, herbs, supplements, etc.			

CHECK (✓) IF YOU ARE ALLERGIC TO			
__Adhesive Tape	__Ibuprofen	__Latex	__Aspirin
__Iodine	__Penicillin	__Local Anesthesia	__Sulfa

List any Allergies to medications or substances:	
Do you take oral contraceptives? __No __Yes	Please list any of the following:

CHRONIC CONDITIONS	ACCIDENTS	DIAGNOSTIC TESTS
INJURIES/ILLNESSES	HOSPITILIZATIONS	SURGERIES

OTHER HEALTH CARE PROVIDERS	
Primary Care	OB/GYN
Preferred Pharmacy	

	Name	Location	Number
Living Will | Advance Directive? __No __Yes		May we have a copy for your chart? __No __Yes	

CERTIFICATION
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child every have a change in health.

_____
Signature of Patient, Parent, Guardian or Personal Representative **DATE**

_____

Please PRINT name of Patient, Parent, Guardian or Personal Representative