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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | |

**MEDICAL ART CENTER |** COVID PATIENT REGISTRATION  
950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenternj.com

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT CONFIDENTIALITY (HIPAA)  Acknowledgment of Receipt of the Notice of Privacy Practices** | | | | | | | |
| **Name** | | | | **Date of Birth** | | | |
|  | | | | **Today’s Date** | | | |
| **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.** | | | | | | | |

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Signature of Patient, Parent, Guardian or Personal Representative** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **DATE** |

I hereby assign the policy rights and benefits to the Doctor,   
and authorize direct payment for professional services rendered.  
I further authorize the attending Doctor to release any information concerning my examination or treatment to my insurance company.   
I agree to be personally responsible for any unpaid balance, deductible or co-payment to the Doctor; and if I perceive   
any payments from my insurance company in error,   
I will sign them directly over to the Doctor.

|  |  |
| --- | --- |
| Date of Last Physical |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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.** | | | | | | | | | | | | | | | | | |
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| **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 | | | | | |
|  | | | | | |  | | | | | |  | | | | | |
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|  | | | | | |  | | | | | |  | | | | | |
| 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 | | | | | | | | |

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| **Signature of Patient, Parent, Guardian or Personal Representative DATE** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Please PRINT name of Patient, Parent, Guardian or Personal Representative** |
|  |

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.