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

|  |
| --- |
| **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 |

|  |
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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.