

MEDICAL ART CENTER | 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	<input type="checkbox"/> Male	Employer	
	<input type="checkbox"/> Female		
Race	Work Phone		
Soc Sec #	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Retired
Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Pharmacy	Phone		
Emergency Contact	Phone		
Referred By: Check All That Apply	<input type="checkbox"/> Friend	<input type="checkbox"/> Family	<input type="checkbox"/> Patient
	<input type="checkbox"/> Facebook	<input type="checkbox"/> Doctor	<input type="checkbox"/> Healthgrades
	<input type="checkbox"/> Billboard	<input type="checkbox"/> TV	<input type="checkbox"/> Work <input type="checkbox"/> Instagram

PATIENT CONFIDENTIALITY (HIPAA) Acknowledgment of Receipt of the Notice of Privacy Practices

Name	Date of Birth
	Today's Date
<p>Patient confidentiality is one of our priorities and it is the law (HIPAA) 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.</p>	
OUR OFFICE MAY LEAVE A MESSAGE AT	
HOME Yes No	CELL Yes No
WORK Yes No	
<p>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</p>	
Name	Relation
Name	Relation
Name	Relation
Name	Relation
Please provide your email address to receive office information?	
Please be advised that it is your responsibility to inform us if any changes should be made to the above information. Thank you.	

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				
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Depression	<input type="checkbox"/> Allergies

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

CHECK (✓) IF YOU ARE ALLERGIC TO			
<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Latex	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Iodine	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Local Anesthesia	<input type="checkbox"/> Sulfa

List any Allergies to medications or substances:

Do you take oral contraceptives? <input type="checkbox"/> No <input type="checkbox"/> Yes	Please list any of the following:
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CHRONIC CONDITIONS	ACCIDENTS	DIAGNOSTIC TESTS
INJURIES/ILLNESSES	HOSPITALIZATIONS	SURGERIES

OTHER HEALTH CARE PROVIDERS		
Primary Care	OB/GYN	
Preferred Pharmacy		
	Name	Location
		Number

Living Will Advance Directive? <input type="checkbox"/> No <input type="checkbox"/> Yes	May we have a copy for your chart? <input type="checkbox"/> No <input type="checkbox"/> Yes
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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