Montville Family Practice Associates

PATIENT INFORMATION

Do you have a Living Will or Advanced Directive? Yes _____ No _____
(If yes, please supply our office with a copy)

PATIENT INFORMATION						
Patient's Last Name: First: MI:					Social Security Number	
Street Address:		City:		State:		Zip:
Home Phone Number:	Cell Phone Number:		Date of Birth:	Marital Status	Sex: ☐ Male ☐ Female	
Employer Name: Address:		City:	State:	Zip:	Occupation:	Work Phone Number:

RESPONSIBLE PARTY (if patient is under the age of 18)						
Person responsible for bill (if patient is under age 18)			Social Security Number:			Date of Birth:
Street Address: (If different from above address)		City:	State:	Zip:	Home Phone Number:	Cell Phone Number:
Employer Name: Address:		City:	State:	Zip:	Occupation:	Work Phone Number:

INSURANCE INFORMATION						
Policyholder Name:			Social Security Number:			Date of Birth:
Street Address:		City:		State:		Zip:
Primary Insurance Company			Policy Number:		Group Number:	
Patient's Relationship to Policyholder:	☐ Self ☐ Spouse ☐ Child ☐Other					
Secondary Insurance Company			Policy Number:		Group Number:	
Patient's Relationship to Policyholder:	☐ Self ☐ Spouse ☐ Child ☐ Other					

IN CASE OF EMERGENCY		
Emergency Contact Name:		Relationship to Patient:
Home Phone:	Cell Phone:	Work Phone:

AUTHORIZATION TO PAY INSURANCE BENEFITS/CONSENT FOR TREATMENT

I hereby authorize payment directly to the physician responsible for my care. I understand that I am financially responsible to my physician for all fees incurred and for fees not covered by this authorization. I authorize the release of my medical information to my third party payer in order to obtain payment. I hereby authorize Montville Primary Care to release any medical information in the course of my examination or treatment. I understand that payment is expected at rendering of service unless other arrangements have been made. I hereby consent to medical treatment for my present condition or injury and for any illness or injury incurred at any time after the date noted below. I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of service.

_____ _____

Patient/Guardian Signature Date:

HEALTH HISTORY

Montville Primary Care Physicians **Patient Name:_____ DOB: _____**
137 Main Road Suite 200 Montville, NJ 07045

Please check if you have had any of the illnesses below:

__ Scarlet fever	__Small pox	__Pneumonia	__Migraine headache	__Diabetes	__Nervous breakdown
__ Arthritis	__Polio	__Rheumatic fever	__High blood pressure	__Hay fever	__Food/Drug Poisoning
__ Bursitis	__Sciatic	__Meningitis	__Low blood pressure	__Asthma	__AIDS
__ Cancer	__Anemia	__Bone/joint disease	__Broken bones	__Hives	__Infections
__ Epilepsy	__Jaundice	__Gonorrhea/Syphilis	__Recurrent dislocations	__Eczema	__Tuberculosis
__ Diptheria	__Neuritis	__Concussion/Head Injury	__Other: _____		

Have you ever had surgery on any of the following:
__Tonsils __Appendix __Gallbladder __Uterus __Ovary __Hemorrhoids
__Upper Extremity _____
__Lower Extremity _____
Have you ever had a blood transfusion? _____
Have you ever had a hernia repaired? _____
Any other operations? _____
List any family illnesses? _____

REVIEW OF CHRONICALLY OCCURRING SYMPTOMS

Please check if you have had any of the following:

__Eye disease	__Fainting spells	__Blood in urine	__Hemorrhoids	__Black, tarry stool
__Eye injury	__Convulsions	__Difficulty in urinating	__Rectal bleeding	__Bowel disease
__Ear disease	__Dizziness	__Narrowed urinary stream	__Parasites	__Changes in bowel pattern
__Ear injury	__Headaches	__Stomach trouble	__Worms	__Constipation
__Impaired hearing	__Night sweats	__Ulcer	__Colitis	__Diarrhea
__Nose problem	__Thyroid problem	__Indigestion	__Appendicitis	
__Mouth problem	__Enlarged goiter	__Changes in eating habits	__Liver disease	
__Throat problem	__Skin disease	__Abnormal thirst	__Chest pain	
__Enlarged glands	__Varicose veins	__Kidney disease	__Fluttering heart	
__Cough	__Swelling of hands	__Kidney stones	__Shortness of breath	
__Spitting up blood	__Swelling of feet			

Have you ever had any of the following tests? (list dates)
_____EKG _____Bloodwork _____X-Rays _____Bone density _____Colonoscopy

SOCIAL HISTORY

Do you have? __Alcohol problem __Drug problem
Do you smoking? __Yes __No __How many packs? _____

Female Information
Age of onset of menstrual cycle _____ Date of last period _____
Are you pregnant now? __Yes __No Have you ever been pregnant? __Yes __No How many children do you have? _____

ALLERGIES

Are you allergic to: __Penicillin __Sulfa Drugs __Aspirin __Codeine __Morphine __Mycins __Tetanus
__Antitoxins __Serums __Any other drugs? _____ Any foods? _____

MEDICATIONS

Please list any medications that you are presently taking: _____
Are you on a prescribed diet? _____ Height: _____ Weight: _____ Right handed? ____ Left handed? ____

PATIENT'S SIGNATURE: _____ **DATE: _____**

MONTVILLE FAMILY PRACTICE ASSOCIATES
137 Main Road Suite 200
Montville, NJ 07045
Phone: 973-402-0025 Fax: 973-402-0508

REQUEST FOR MEDICAL RECORDS

****I, _____, do hereby consent Montville Family Practice Associates to obtain information from my medical records relating to my treatment. This release is to be limited to the specified reports within the specified dates of treatments I have indicated below. I understand that this consent shall operate as a complete release of liability to:**

_____
(hospital or medical facility name), and its employees for the release of the information as specified below.

****PATIENT NAME: _____**

**** DOB: _____**

TREATMENT DATES NEEDED: _____

REPORTS NEEDED: _____

SPECIAL INSTRUCTIONS: _____

I understand that once my health information is released to the above recipient, your hospital or medical facility cannot guarantee that the recipient will not disclose my health information to a third party. I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorized,
_____,
(hospital or medical facility name), to disclose my health information in the manner described above.

****_____ _____**
Patient Signature Date

If the individual is a minor or is otherwise unable to sign this authorization, please complete the information below:

_____ _____
Signature of Authorized Legal Guardian Date

_____
Relationship to Patient

Consent to request medical records

MONTVILLE FAMILY PRACTICE ASSOCIATES
137 Main Road Suite 200
Montville, NJ 07045
Phone: 973-402-0025 Fax: 973-402-0508

INSURANCE COMPANIES WILL NOT PAY PROVIDERS IF CLAIMS ARE NOT SUBMITTED WITHIN 60 DAYS. THEREFORE, IT IS IMPORTANT FOR OUR PATIENTS TO PROVIDE THE CORRECT INSURANCE INFORMATION AT THE TIME OF SERVICE.

IF I, _____, DO NOT PROVIDE THE CORRECT INSURANCE AT THE TIME OF VISIT I AM FULLY RESPONSIBLE FOR THE CHARGES.

_____ _____

SIGNATURE OF PATIENT **DATE**

MONTVILLE FAMILY PRACTICE ASSOCIATES
137 Main Road Suite 200
Montville, NJ 07045
Phone: 973-402-0025 Fax: 973-402-0508

PERMISSION TO RELEASE MEDICAL INFORMATION

I, _____, give Montville Family Practice Associates permission to release any medical information requested by _____.

_____ _____

Signature of Patient **Date**

MONTVILLE FAMILY PRACTICE ASSOCIATES
137 Main Road Suite 200
Montville, NJ 07045
Phone: 973-402-0025 Fax: 973-402-0508

RECEIPT OF PRIVACY PRACTICE NOTICE
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, am aware that a copy of the Notice of Privacy Practices is available for my review at the office's front reception. I have read and understand the terms and conditions.

_____ _____
Signature of Patient Date

FOR YOUR CONVEINENCE, OUR OFFICE CAN MAKE A COPY OF THIS DOCUMENT UPON REQUEST

MONTVILLE FAMILY PRACTICE ASSOCIATES
137 Main Road Suite 200
Montville, NJ 07045
Phone: 973-402-0025 Fax: 973-402-0508

REQUEST FOR MEDICAL RECORDS

TO: _____

_____

_____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

MONTVILLE FAMILY PRACTICE ASSOCIATES
137 MAIN ROAD SUITE 200
MONTVILLE, NJ 07045

_____ **_____**
PATIENT SIGNATURE **DATE**

_____ **_____**
PRINT NAME **DATE OF BIRTH**