URGENT CARE OF NEW JERSEY

Patient Registration Form

Please fill-out completely.

PLEASE CIRCLE, ARE YOU HERE FOR?
Auto Accident Injury: YES OR NO
Workers compensation Injury: YES OR NO

Patient's Full Name:	Social Security Number: _____-_____-_____
Date of Birth: _____/_____/_____	Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered
Sex: □ M □ F □ Mr. □ Ms. □ Mrs.	Primary Care Physician:
Street Address:	Email Address:
City, State, Zip:	Preferred Pharmacy: **(Name and Location)**
Home Phone:	
Work Phone:	**REASON FOR VISIT:** / **Symptoms began...?** □ _____ hours □ _____ days □ _____ weeks
Cell Phone:	

EMERGENCY CONTACT:

Contact Full Name:	Relationship to Patient:
Phone Number: □ Cell □ Home	

Who May We Disclose Your Medical Information With? (If no one then please leave blank)

Name:	Phone Number:

INSURANCE INFORMATION: (if main card holder is someone other than patient)

Insurance Company:	Copay Amt:	Employer:
Main Card Holder:	Card Holder Date of Birth: _____/_____/_____	Relationship to Patient: □ Self □ Parent □ Spouse □ Partner
Card Holder Social Security No.: _____-_____-_____	Card Holder's Address: (only if different from patients) Street: _____ City: _____ State: _____ Zip: _____	

I have reviewed the Urgent Care of NJ terms and conditions and accept financial responsibility in full for this account. I am aware that it is my responsibility to know if I require a referral and that I have 48 hours to obtain one if needed. I also confirm that all the above information is correct and understand that this information will only be used inside this medical practice in accordance to HIPAA standards. OFFICE POLICY ON PAYMENT: It is our policy to collect all office charges at the time services are rendered. I also acknowledge that if I desire to acquire and of my medical records including but not limited to x-rays, labs, and medical history that I will incur a charge of 25 cents per page plus a reasonable clerical fee. Medical Records belong to the physician's office and any x-ray or diagnostics fees were for the expertise and equipment/supplies used, not for the copies themselves.

SIGNED: _____ DATE: _____

← FILL OUT BACK →

PLEASE FILL ALL THE FOLLOWING:

Last Known Menstrual Period: (females only)

- □ Currently
- □ Menopausal
- □ _____ weeks ago
- □ Pregnant for _____ weeks
- □ Hysterectomy
- □ Hormone/IUD

Height: _____ ft _____ in

Drug Usage:

- □ Never
- □ Occasionally use: _____

Smoking:

- □ Never Smoked
- □ Smokes _____ per day
- □ Former Smoker: Started ____yrs & Quit ____yrs

When was your last Tetanus Shot?:

- □ _____ years
- □ _____ months

Alcohol – Type of Drinker:

- □ No alcohol consumption
- □ Social Drinker □ Binge
- □ Daily □ Alcoholic

Employment Status:

- □ Homemaker □ Student
- □ On disability □ Retired
- □ Employed □ Unemployed

Number of Children:

- □ Of your own _____
- □ Adopted _____
- □ Step children _____

Living:

- □ Alone
- □ With Family
- □ With Roommate
- □ Assisted Living
- □ With Boyfriend
- □ With Girlfriend
- □ With Partner
- □ Homeless

Do you have any medical conditions?
(ie. Diabetes, Autism, Asthma etc.)

Allergies: □ No known Allergies

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

Medications: (plus dosage) □ No medications taken

1. _____ - _____ mg - for: _____
2. _____ - _____ mg - for: _____
3. _____ - _____ mg - for: _____
4. _____ - _____ mg - for: _____

List All Prior Hospitalizations: (and when)

List All Past Surgeries: (and when)

Caffeine:

- □ Never
- □ Occasionally
- □ ___ cups tea/day
- □ ___ cups coffee/day
- □ ___ cups soda/day

Diet:

- □ Healthy
- □ Unhealthy

Exercise:

- □ None
- □ Sporadic
- □ Daily

Sleeping Habits:

- □ No sleeping problems
- □ Occasional sleep problems
- □ Have sleeping problems

Check off if anyone in your family has had any of the following:

- □ Coronary artery disease
- □ Hypertension
- □ Migraine
- □ Stroke
- □ Cancer
- □ Alzheimer's
- □ Depression
- □ Manic depression
- □ Schizophrenia
- □ ADHD
- □ Parkinson's
- □ Seizures
- □ Epilepsy
- □ Multiple sclerosis
- □ Diabetes Type 1
- □ Diabetes Type 2
- □ Hyperthyroidism
- □ Sickle cell anemia
- □ Allergies
- □ Asthma
- □ COPD
- □ TB
- □ Cystic fibrosis
- □ Alcoholism
- □ Kidney disease
- □ Osteoporosis

Is Your Mother:

- □ Alive with no problems
- □ Alive with medical problems
- □ Deceased

Is Your Father:

- □ Alive with no problems
- □ Alive with medical problems
- □ Deceased

FOR CHILDREN PLEASE ALSO FILL:

Are immunizations up to date? □ Yes □ No

Is family employed? □ Yes □ No

Is there a smoker in family? □ Yes □ No

If child attends day care name of daycare: _____

By signing below you are stating that all the above information is current and true.

SIGNED: _____ DATE: _____