PATIENT INFORMATION FORM

WELCOME TO OUR OFFICE

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Telephone (973)998-8900

TODAY'S DATE_____

REFERRED BY_____

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION
ALL INFORMATION IS STRICTLY CONFIDENTIAL
(Please Print Clearly)

PATIENT NAME_____ BIRTHDATE_____

SS#_____ MARITAL STATUS_____ EMAIL_____

ADDRESS_____

HOME PHONE ( )_____ WORK PHONE ( )_____ CELL PHONE( )_____

EMPLOYER_____ ADDRESS_____

NAME OF SPOUSE (OR PARENT/GUARDIAN)_____ ADDRESS_____

SS# OF SPOUSE (OR PARENT/GUARDIAN) _____ PHONE ( )_____

CHIEF COMPLAINT/REASON FOR VISIT_____

NAME OF PRIMARY CARE PHYSICIAN _____ DATE OF LAST VISIT_____

LIST ANY ALLERGIES (DRUGS, FOOD, HAYFEVER, OTHER)	LIST ANY MEDICATIONS	LIST ANY SURGERY

CHECK OFF ANY CONDITIONS WE SHOULD KNOW ABOUT:

☐ DIABETES, ☐ HYPERTENSION ☐ HEART PROBLEM, ☐ BREATHING PROBLEM, ☐ LIVER OR KIDNEY PROBLEM,

☐ HIGH CHOLESTEROL, ☐ ARTHRITIS, ☐OTHER_____

DESCRIBE _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

SIGNED_____ DATE_____
(Patient, or Parent/Guardian if Minor)

RELEASE OF INFORMATION
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM

SIGNED_____ DATE_____
(Patient, or Parent/Guardian if Minor)

THANK YOU FOR CHOOSING OUR OFFICE!