

Middlesex Community Medical Care

REGISTRATION FORM

(Please Print)

Today's Date:										
PATIENT INFORMATION										
Patient's Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status:				
						Single <input type="checkbox"/>	Mar <input type="checkbox"/>	Div <input type="checkbox"/>	Sep <input type="checkbox"/>	Wid <input type="checkbox"/>
Email Address:			Social Security no.:		Birth date:		Age:	Sex:		
			- -		/ /			<input type="checkbox"/> M <input type="checkbox"/> F		
Street address:				Home phone no.:		Cell phone no.:				
				()		()				
City:					State:		ZIP Code:			
Occupation:		Employer:				Employer phone no.:				
						()				
Emergency Contact:				Contact phone no.:		Relationship:				
				()						
Pharmacy Name:				Pharmacy phone no.:		City:				
				()						

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.:	
						()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.:	
						()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Primary insurance Name:							
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Policy no.:	Group no.:	Co-payment:	
		- -	/ /			\$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of Secondary insurance (if applicable):			Subscriber's name:		Policy no.:	Group no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

PATIENT AND RESPONSIBLE PARTY AUTHORIZATION							
*Required by HIPAA							
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Middlesex Community MedicalCare LLC or insurance company to release any information required to process my claims. I permit a copy of this authorization to be used in place of the original.</p> <p>IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN AND/OR PARENTS RESPONSIBILITY. Finance charge (no charge if paid in 30 days of billing date) is computed by a "Periodic Rate" of 1½% per month, which is an ANNUAL PERCENTAGE RATE of 18% applied to the previous balance without deducting current payments and/or credits appearing in any given bill. Patient or responsible party(ies) further agree to pay any and all collection fees incurred in legal expenses, including but not limited to all collection Agency and Attorney fees (at 33%), or court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debts.</p>							
<hr style="width: 100%;"/>						<hr style="width: 100%;"/>	
Patient/Guardian signature:						Date:	

MEDICAL HISTORY

Patient's Name:		Birth Date:	/ /
Reason for visit:			
Allergies:			

CURRENT MEDICATIONS:	DOSAGE	FREQUENCY

PAST MEDICAL HISTORY/ PAST SURGICAL HISTORY:		
1.		6.
2.		7.
3.		8.
4.		9.
5.		10.

FAMILY HISTORY:		RELATION
1.	High Blood Pressure	
2.	Diabetes	
3.	Heart Disease	
4.	Cancer	
5.	Stroke	
6.	Other	

SOCIAL HISTORY (LIST AMOUNTS AND FREQUENCY OF USE):	
Alcohol	Street Drugs
Tobacco	Occupational Hazards

IMMUNIZATIONS (DATES):					
Tetanus:	TB Skin Test:	Flu Shot :	Pneumovax :	Hep.B :	Hep.C :

SCREENING TESTS (DATES):			
Pap smear		(Normal/Abnormal)	Colonoscopy
Mammogram		(Normal/Abnormal)	PSA
Bone Density		(Normal/Abnormal)	Last Physical
Heart Disease		(Normal/Abnormal)	

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____ / _____ / _____

Phone no.: _____ (_____) _____ Social Security #: _____ - _____ - _____

Patients' Address: _____

Street Name/Appt #

City

State

Zip Code

I request and authorize to release healthcare information of the patient named above from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone no.: _____ (_____) _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken.

Patient/Guardian Signature: _____ Date: _____