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Account No.	Entered Date
Reg. By	Office Site
☐ New ☐ Change	Info. Change:

Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Information

Patient Last Name: _____

First Name: _____ MI _____

Other Name: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Addr1: _____

Addr2: _____

City, State, Zip: _____

Preferred Method of Contact: ☐ Alt Phone Number ☐ Email ☐ Letter ☐ Phone Call (Cell) ☐ Phone Call (Home)

Driver's License # (DL#) _____ State(ST) _____

Emp. Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other _____

Language: ☐ English ☐ Spanish ☐ Other _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Race: (please choose one of the following):
☐ American Indian ☐ Asian ☐ African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
☐ Unknown ☐ Patient Refused

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other ☐ Patient Refused

Home Phone: (_____) _____

Alt Phone: (_____) _____

Home E-Mail: _____

Cell Phone: (_____) _____

Employer: _____

Address: _____

City, State, Zip: _____

Work Phone: (_____) _____

INSURANCE INFORMATION (A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

SECONDARY CARRIER: _____

Address: _____

Group/Plan #: _____ Effective Date: _____

Subscriber's DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Telephone #: (_____) _____

ID/Cert #: _____

Subscriber's Name: _____

Relationship to Patient: _____

Primary Care Phys.: _____

Address: _____

City, St., Zip: _____

Telephone #: _____

Refer. Phys. (if different): _____

Address: _____

City, St., Zip: _____

Telephone #: _____

Pharmacy Name, Address & Phone #: _____

REVIEW OF SYSTEMS

Systemic			***Ears/Nose/Throat***			***Stomach/Intestines***		
Fever	Y	N	Hearing Loss	Y	N	Abdominal Pain	Y	N
Weight Change	Y	N	Ear Ringing	Y	N	Nausea	Y	N
Fatigue	Y	N	Sore Throat	Y	N	Vomiting	Y	N
Weakness	Y	N	Hoarseness	Y	N	Stool Change	Y	N
						Diarrhea	Y	N
Neck			***Heart***			Constipation	Y	N
Pain	Y	N	Chest Pain	Y	N	Hemorrhoids	Y	N
Lumps	Y	N	Palpitations	Y	N	Blood in Stool	Y	N
Swollen Glands	Y	N	Shortness of Breath	Y	N			
						Bladder		
Eye			***Lung***					
Blurry Vision	Y	N	Difficulty Breathing	Y	N	Burning w Frequency	Y	N
Double Vision	Y	N	Wheezing	Y	N	Night-time Urination	Y	N
Pain	Y	N	Coughing up Blood	Y	N			
						Circulation		
Psychological			***Glands***					
Depressed	Y	N	Hair Loss	Y	N	Easy Bleeding	Y	N
Anxiety	Y	N	Weakness	Y	N	Anemia	Y	N
Sleep Issues	Y	N						
			Bones/Joint			***Skin***		
Nervous System			Joint Pain	Y	N	Hives	Y	N
Headache	Y	N	Joint Swelling	Y	N	Mole Change	Y	N
Dizziness	Y	N	Back Pain	Y	N			
Fainting	Y	N	Joint Stiffness	Y	N			

Family History: ***Please list specific family member (father, mother, brother, sister, maternal or paternal grandparent)***

Breast Cancer: _____ Diabetes: _____

Cervical Cancer: _____ Thyroid Disorders: _____

Colon Cancer: _____ Obesity: _____

Lung Cancer: _____ Crohn's Disease: _____

Ovarian Cancer: _____ Colitis: _____

Prostate Cancer: _____ COPD: _____

Uterine Cancer: _____ Other: _____

Heart Disease: _____ _____

Stroke: _____ Hypertension: _____

NAME: _____ ***DOB***: _____

MEDICAL HISTORY

Anxiety	Y	N	Hematologic Disorder (bleeding disorder)	Y	N	***Never a Smoker***	( )
Arthirits	Y	N					
Atrial Fibrillation	Y	N	High Cholesterol	Y	N	***Current Smoker***	YES NO
ASCVD	Y	N	High Blood Pressure	Y	N	how much: _____	
Asthma	Y	N	Kidney Disease	Y	N	how long: _____	
Bell's Palsy	Y	N	Migraines	Y	N	***Former Smoker***	Yes NO
Bleeding History	Y	N	Mitral Valve Prolapse	Y	N	How much: _____	
Cancer	Y	N	Obesity	Y	N	when did you quit?_____	
COPD (emphysema)	Y	N	Osteoporosis	Y	N	***How long did you smoke for?*** _____	
CVA (stroke)	Y	N	Parkinson's Disease	Y	N	***Caffeine***	YES NO
Dementia	Y	N	Pneumonia	Y	N	how much: _____	
Depression	Y	N	Pulmonary Embolism	Y	N	***Alcohol***	YES NO
Diabetes	Y	N	Seizures	Y	N	how much: _____	
Diverticulitis of Colon	Y	N	Sleep Apnea/Snoring	Y	N	***Other tobacco use***: _____	
Arterial Thrombosis	Y	N	Thrombophlebitis	Y	N		
DVT (leg blood clots)	Y	N	Thyroid Disorders	Y	N	***Any recent travel?***	YES NO
GERD/Indigestion	Y	N	TIA	Y	N		
Glaucoma	Y	N	Trouble w Anesthesia	Y	N	***CURRENT MED LIST***	
HIV	Y	N	Varicose Veins	Y	N	_____	
Hepatitis	Y	N	Vascular Disease	Y	N	_____	
						_____	
						_____	

SURGICAL HISTORY

Anal Surgery	Y	N	Pacemaker Placement	Y	N	_____	
Appendectomy	Y	N	Defibrillator	Y	N	_____	
Bariatric Surgery	Y	N	Pilonidal Cyst Resection	Y	N	_____	
Breast Surgery	Y	N	Hysterectomy	Y	N	_____	
Cardiac Surgery	Y	N	Orthopedic Surgery	Y	N	_____	
Cardiac Cath & Stent	Y	N	Prostatectomy	Y	N	***ANY DRUG ALLERGIES***: _____	
Cesarean Section	Y	N	Spinal Surgery	Y	N	_____	
Cholecystectomy	Y	N	Tubal Ligation	Y	N	_____	
(gallbladder) date: _____			Thorax Surgery	Y	N	_____	
Colonoscopy	Y	N	Thyroid Surgery	Y	N		
What year: _____			Tonsillectomy	Y	N	***CURRENT PHARMACY***:_____	
Fractures	Y	N	Vasectomy	Y	N	_____	
GI Surgery	Y	N	**What kind of Orthopedic Surgery:			***City***: _____	
Hemorrhoid Surgery	Y	N	_____			***Phone#*** _____	
Hernia Surgery	Y	N	_____				

Date of last mammogram: _____ Any other previous surgeries? _____

Name: _____ ***DOB***: _____

Chief complaint:_____ ***Location of problem***: _____

Severity of problem: _____ ***When did the problem start?*** _____

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IDX Account #:_____

Assignment of Benefits/Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Advocare Payment Policy and Notice of Privacy Practices for more information)

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

New Jersey Vaccine Registry (if applicable)

Please be advised that our office submits information of your child's vaccinations to the NJIIS (New Jersey Immunization Information System). The purpose of this program is to keep a central record of your child's immunization history.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

_____ X _____

Patient Name (Please Print) Patient Signature

_____

Guarantor/Parent/ Guardian completing this form (Please Print) Date

X _____

Guarantor/Parent/ Guardian Signature Date

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	☐ Y ☐ N	Has treatment been authorized by the V.A.?	☐ Y ☐ N
Do you or your spouse have other insurance?	☐ Y ☐ N	Are you covered under the Black Lung Program?	☐ Y ☐ N
Are you disabled or have end stage renal disease?	☐ Y ☐ N	Is there Medigap coverage secondary to Medicare?	☐ Y ☐ N
Is illness/injury the result of an auto accident?	☐ Y ☐ N	Is there insurance coverage primary to Medicare?	☐ Y ☐ N
Did illness/injury occur at work?	☐ Y ☐ N	Is there employer supplemental coverage secondary to Medicare?	☐ Y ☐ N

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ X _____

Patient Name (Please Print) Patient Signature

_____

Guarantor/Parent/ Guardian completing this form (Please Print) Date

X _____

Guarantor/Parent/ Guardian Signature Date

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HIPAA Acknowledgement

Notice of Privacy Practices

Print Name of Patient _____

Patient Date of Birth _____

We at Advocare are required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices with respect to protected health information. I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Signature of Patient/Legal Representative _____

Today's Date_____

Email Address of Patient/Legal Representative _____

Cell Phone of Patient/Legal Representative (_____) _____ - _____

Please let us know which number you would like us to call regarding your medical information. *Note that this is the number where we will leave a message if we do not reach you.*

☐ Home phone ☐ Cell phone ☐ Both