AtlantiCare PRIMARY CARE PLUS | FAMILY MEDICINE CENTER

PATIENT REGISTRATION FORM

Patient Information

Reason for Visit (if injury how did it occur): ____

If injury, is it related to: Worker's Comp? Y / N Motor Vehicle? Y / N Please give date of injury: ___/___/____

First Name: ______________________________ Middle Initial: ____ Last Name: ______________________

Social Security #: _____/_____/_____ Date of Birth: ___/___/_____ Age: _________

Sex (circle one): Male/Female/Transgender Marital Status (circle one): S/M/D/W/Partner

Address: __________________________ City: ___________ State: ________ Zip Code: __________

Home Phone#: (___)-_____-_______ Cell Phone#: (____)-_____-_______ Work Phone#: (___)-_____-_______

Emergency Contact Information: (if patient is an adult) or Parent/Guardian Information *(if patient is a minor)*:

First Name: ______________________________ Middle Initial: ____ Last Name: ______________________

Relationship to Patient: __________________________

Home Phone#: (___)-_____-_______ Cell Phone#: (____)-_____-_______ Work Phone#: (____)-_____-_______

Employment Status (circle one): Full-time / Part-time / Self Employed / Retired / Military

Patient's Occupation: ________________________________ Work#: (____)-_____-_______

Employer Name: ____________________________________

Address: __________________________ City: ___________ State: ________ Zip Code: __________

Is it okay to leave messages at: Work? Y / N

If Student, indicate School __________________________ Student Status (circle one): FT/ PT

Do you have an Advance Directive? (circle one) Y / N, If no would you like information about it? (circle one): Y / N

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Insurance Information:

Primary Insurance Name: ____

If Medicare: Is the patient a Veteran? (circle one) Y / N Is your spouse/partner currently employed? (circle one) Y / N

Policy/Subscriber ID#: ____________________ Group#: ____________________

How is the Subscriber related to you? (circle one) Self / Spouse / Child / Guardian

Policyholder / Subscriber Information:

First Name: ____________________________ Middle Initial: _____ Last Name: ______________________

Social Security #: _____/_____/_____ Date of Birth: ____/____/______ Age: __________ Sex: M / F/ T

Address: ________________________ City: ___________ State: ________ Zip Code: __________

Home Phone#: (___)-_____-_______ Cell Phone#: (___)-_____-_______ Work Phone#: (___)-_____-_______

Secondary Insurance Name: ____

If Medicare: Is the patient a Veteran? (circle one) Y / N Is your spouse/partner currently employed? (circle one) Y / N

Policy/Subscriber ID#: ____________________ Group#: ____________________

How is the Subscriber related to you? (circle one) Self / Spouse / Child / Guardian

Policyholder / Subscriber Information:

First Name: ____________________________ Middle Initial: _____ Last Name: ______________________

Social Security #: _____/_____/_____ Date of Birth: ____/____/______ Age: __________ Sex: M / F/ T

Address: ________________________ City: ___________ State: ________ Zip Code: __________

Home Phone#: (___)-_____-_______ Cell Phone#: (___)-_____-_______ Work Phone#: (___)-_____-_______

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Additional Information:

E-mail address: ______________________________ Preferred Method of Contact (circle one): Home/Cell/Email

Is it okay to leave message at: Home? (circle one) Y / N   Cell? (circle one) Y / N

Primary Language: ____

Ethnicity: _________________________ Race: _____________________

Translator Services required? (circle one) Y / N

Are you visually impaired? (circle one) Y / N   Are you hearing impaired? (circle one) Y / N

Pharmacy Information:

Retail Pharmacy Name: ________________________ Location: ___________________________________

Phone#: (____)-_____-________   Fax Phone#: (____)-_____-________

ID# ______________________

Mail Order Pharmacy: ________________________

Phone#: (____)-_____-________   Fax Phone#: (____)-_____-________

ID# ______________________

Preferred Lab Company: (circle one) AtlantiCare Labs (ACL) / Lab Corp / Quest

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Today's Date____/____/______

Patient's Name:________________________________DOB: ____________________________

MEDICAL HISTORY: (please check all that apply)

High Blood Pressure	Drug Abuse
High Cholesterol	Alcohol Abuse
Diabetes	Ulcers
Cancer	Hepatitis
Tuberculosis	HIV
Urinary Tract	Thyroid
Infections	Asthma
Anemia	COPD
Kidney Stones	Stroke
Kidney Disease	Angina
Gallbladder Disease	Lyme's Disease
Heart Disease	Arthritis
Depression	Other (please describe)

Do you have any Allergies to Medication, food or other: Y / N

Surgical History: (please list type of surgery, if any, and date)

Family History: (please check all that apply)

Blood Pressure	Stroke
Diabetes	Heart Attack
Cancer	Kidney Disease
Other (please describe)	Depression

Social History

Alcohol:	Y / N	If yes, how many drinks are consumed, per week?
Cigarettes:	Y / N	If yes, how many packs per day?

Other treating providers: (please list the name and specialty of any other provider currently treating you)

Name:________________________________ Specialty:____________________________

Name:________________________________ Specialty:____________________________

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Today's Date: ______/ _____/ ______

Patient Name: ______________________________ DOB: _____/ _____/ _______

Please list all medications including vitamins and over the counter supplements and medications

Medication	MG/ Strength	Dose/ How Often

***NOTE:** It is always best to bring in your all medication, supplements and vitamins to all your medical visits.

Thank you for choosing Atlanticare Family Medicine Center, Little Egg Harbor, to be you primary care physician. We look forward to meeting you and providing quality care for you.

*Please arrive at office 15 minutes prior to your scheduled appointment

*Please bring completed new patient paperwork, your insurance cards, photo ID, any current medications (preferably in the container), including any over the counter medication, and your co-pay, if applicable.

*If you need to cancel, re-schedule, or have further questions, please call us at 609-296-1101

FAMILY MEDICINE CENTER

APG FMC Mathistown
200A Mathistown Road
Little Egg Harbor, NJ 08087

CONSENT TO DISCUSS CARE & TREATMENT

Patients Name:________________________________ Birthdate:____/____/____

I allow my medical practice(s) to provide the following information to the phone number(s) listed below.

☐ Appointments
☐ Results/Plan of Care
☐ Voicemail permission
____
Patient's Phone (Home)

☐ Appointments
☐ Results/Plan of Care
☐ Voicemail permission
____
Patient's Phone (Cell)

I permit the following information to be discussed with the following family member, friend or others person or persons listed below.

I understand that if I want any of the persons listed below to receive a copy of my records; I must complete and sign a separate authorization form.

In an emergency or if I am admitted to the hospital and unable to make my wishes known, I understand that my provider and hospital staff may rely on the above permissions to determine with whom they may discuss my care.

I can change the permissions stated below at any time by notifying my provider or AtlantiCare's Privacy office.

☐ Appointments only
☐ Results/ Plan of care: ____
☐ My bill
Name Relationship Phone

☐ Appointments only
☐ Results/ Plan of care: ____
☐ My bill
Name Relationship Phone

☐ Appointments only
☐ Results/ Plan of care: ____
☐ My bill
Name Relationship Phone

Patient
Signature:________________________________ Date:____________

Print name:________________________________

Signature of lawful personal representative[1]:________________________ Phone:____________

Print name:________________________________

[1]Required only if the patient is a minor or unable to represent self

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf, to release the health information for:

Name (Please Print) Date of Birth

To the person or entity listed below:

Recipient's name: APG FMC Mathistown

Recipient's Address: 200A Mathistown Road, Little Egg Harbor, NJ 08087

Recipient's Telephone: 609 296 1101 Recipient's Fax: 609 296 9653

Information to be released from records pertaining to:

☐ Ambulatory ☐ Inpatient ☐ Emergency Department ☐ Other ____________

For date(s) of service: ____

Specific Information to be Released:

☐ Complete medical record	☐ Radiology
☐ Laboratory tests	☐ Cardiac tests
☐ Alcohol/Substance Abuse	☐ AIDS/HIV
☐ Mental Health	☐ Psychotherapy Notes

Other (specify) ____

Information is to be released for the purpose of treatment and continuity of care.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare's compliance with this request. The revocation must be in writing and is subject to terms described in AtlantiCare's Notice of Privacy Practices and other AtlantiCare policies.

I understand that I am not required to sign this authorization and that AtlantiCare may not condition treatment or services on my execution of this authorization.

I understand that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protected by HIPAA.

This authorization will expire upon the release of the information described above or four (4) months after the date of the authorization, unless specified otherwise. Expiration date:

Signature of Patient or Personal Representative: Date

Personal Representative's relationship to Patient:

Reason patient cannot sign

Patient is entitled to a copy of signed authorization.

Updated 04/01/2014 IV

NO CDs/Disks Thank You

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Please Read!

APG FMC Refill Policy

Prescription refills should be requested during your office visit!

Physicians ask that you bring your medication bottles with you in a bag to all routine, physical and wellness visits. This will help ensure accuracy of medication reconciliation.

Please give **ONE WEEKS NOTICE for ALL prescription refill requests outside of an office visit**, allowing 7 days for medication to be refilled.

We recommend you call to request refills on the day your doctor is in the office.

The Physician On-Call does not do prescription refills.