



1175 Roosevelt Avenue
Carteret, NJ 07008
Telephone: (732) 541-2233
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PATIENT INFORMATION FORM

Cell Phone()- -

Name _____ Home Phone()- -

Home address _____
Street Town State zip code

Social Security Number - - Date of Birth / /

Spouses' Name _____ Phone No. ()- -

Nearest relative
not living with you _____ Phone No.()- -

Employer _____ Phone No. ()- -

Address _____
Street Town State Zip code

Primary physician _____ Phone No.()- -

Who may we contact in case
of emergency? _____ Phone No.()- -

Who may we thank for
referring you? _____ Phone No.()- -

Who is responsible for this bill? _____

I will be paying today by: cash ___ check ___ credit card ___ Insurance ___

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of the sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature _____ Date _/ _/ _

Patient (if minor) _____ Date _/ _/ _



Check any of the following that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Goiter | <input type="checkbox"/> Cardiac disease |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Influenza | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Anorexia/Bulimia |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Mental disorder | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Eczema | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Small Pox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Menstrual irregularities |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hypertension | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Easy bleeding/bruising | <input type="checkbox"/> Numbness, tingling, pins and needles |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Bladder incontinence | <input type="checkbox"/> Bowl Irregularity |
| <input type="checkbox"/> Anxiety | | |

ADDITIONAL MEDICAL INFORMATION:

Have you been hospitalized in the past 12 months if so why? _____
Where _____ When: _____

Have you had any surgeries Yes NO What type of surgery was performed _____
WHEN _____ WHERE _____

ARE YOU PREGNANT YES NO LAST MENSTRUAL PERIOD _____.

Do you have any allergies to medications, if so what medications _____
What was your reaction _____

PLEASE LIST ALL CURRENT MEDICATIONS: _____

ARE YOU ON ANY BLOOD THINNING MEDICATION: YES NO : SUCH AS WAFARIN, PLAVIX, COUMADIN

DO YOU SMOKE: CIGARS YES/NO (#PER DAY) CIGARETTES YES/NO (#PER DAY) PIPE _____

DO YOU USE ALCOHOL: YES/NO # PER DAY _____.

DO YOU USE DRUGS: YES/NO: MARAJUANA COCAINE HEROIN

IS THERE A FAMILY HISTORY (mother, father siblings) OF DIABETES, HYPERTENSION, HEART DISEASE, STROKE, THYROID PROBLEMS OR CANCER, if so please explain _____ explain _____

Date: _____ Name: _____

