

**PRIMARY CARE ASSOCIATES OF NEW JERSEY, LLC  
PATIENT REGISTRATION & HEALTH QUESTIONNAIRE**



PATIENT Name: Last:		First:	Middle:
Street Address:			
Zip:	City:	State:	
Home Phone:		Work Phone:	Cell Phone:
Sex:	SS#:	Date of Birth:	Marital Status:
Employer/School Name & Address:			
Spouse's Name:			Date of Birth:
Spouse's Employer:			Phone No:
Father's Name (if patient is minor):			Phone No:
Father's Address:			
Mother's Name (if patient is minor):			Phone No:
Mother's Address:			
Emergency Contact:		Referred By:	

**INSURANCE & BILLING INFORMATION**

Name of Person Responsible for Bill:		Relationship:
Address:		Phone:
Primary Insurance Name:		
Name of Insured:	DOB:	Relation to Patient:
Secondary Insurance Name:		
Name of Insured:	DOB:	Relation to Patient:
Laboratory to be used as required by your insurance - if known:		

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct Payment of surgical / medical benefits to Primary Care Associates of New Jersey, LLC for services rendered by their practitioners or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I also give my permission to PCANJ, LLC to act as my agent with regard to any of my insurance issues.

A photocopy / scanned copy of these assignments shall be as valid as the original.

Patient Name (please print):	
Signature:	Date:
If the person signing is not the Patient, please print your name and your relationship to the Patient.	
Name (printed):	Relationship to Patient:

**ACKNOWLEDGMENT OF PRIVACY PRACTICES NOTIFICATION**

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Primary Care Associates of New Jersey, LLC.

Signature:	Date:
If the person signing is not the Patient, please print your name and your relationship to the Patient.	
Name (printed):	Relationship to Patient:
For office use: If unable to obtain acknowledgement state reasons why efforts made to obtain acknowledgement.	

**PERMISSION TO DISCLOSE MEDICAL INFORMATION TO ANOTHER**

With regard to my medical condition and medical records, I give permission to the Staff of Primary Care Associates of New Jersey, LLC to speak to the person(s) listed below. (You may indicate "no one".) Permission remains in effect until such time that it is specifically revoked. You may, at any time, revoke any and all designees. Other healthcare professionals and entities not be listed.

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Patient Signature:	Date:

# PRIMARY CARE ASSOCIATES OF NEW JERSEY, LLC COMPLETE PHYSICAL HEALTH QUESTIONNAIRE



Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation / Employer: \_\_\_\_\_

### FAMILY HISTORY

Next to each family member listed, please indicate the relative's **age**, **(A)**live or **(D)**eceased, and their Health Status as **(G)**ood or **(P)**oor. Use the space provided to list any other significant medical conditions/ illnesses in family members.

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Sisters: \_\_\_\_\_ Brothers: \_\_\_\_\_

### HEALTH HISTORY:

BELOW PLEASE INDICATE ALL BLOOD RELATIVES OF **THE PATIENT** WHO HAVE HAD ANY OF THE FOLLOWING PROBLEMS. PLEASE USE THE FOLLOWING ABBREVIATIONS: (P) PATIENT, (F) FATHER, (M) MOTHER, (B) BROTHER, (S) SISTER, (MM) MOTHER'S MOTHER, (MF) MOTHER'S FATHER, (FM) FATHER'S MOTHER, (FF) FATHER'S FATHER, (A) AUNT, (U) UNCLE, (C) COUSIN

Alcoholism	Cancer	Glaucoma	Measles	Strep Throat
Anemia	Chicken Pox	Hayfever	Mental Illness	Stroke
Arthritis	Cystic Fibrosis	Heart Disease	Migraine	Sudden Infant Death
Asthma	Diabetes	Hepatitis	Mumps	Thyroid
Birth Defects	Early Deafness	High Blood Pressure	Osteoporosis	Urinary Infections
Bleeds easily	Eczema / Hives	High Cholesterol	Scarlet Fever	Whooping Cough
Blood Transfusions	Epilepsy	Joint Problems	Seizures	

List any other medical history, with details & dates, and any other changes in medical or personal information we should know.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Alcohol _____ oz per wk Preference:	Smoking: _____ cigarettes/day for _____ # years Year quit _____	Street Drugs: Y / N Type?	Exercise? Y / N Type: Times/week: Min/time:	<b>MALES:</b> Prostate Trouble Y / N Premature Ejaculation? Y / N Difficulty attaining / sustaining erection? Y / N
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**FEMALES:** Menstrual Flow: Regular? Y / N Menstrual Pain / Cramps? Y / N Pain / Bleeding during or after sex? Y / N

First day of last period (date): \_\_\_\_\_ Number of days of flow: \_\_\_\_\_ Length of Cycle: \_\_\_\_\_

Flushing or Menopause? Y / N Birth control method? \_\_\_\_\_ Name of birth control pills? \_\_\_\_\_

Number of Pregnancies? \_\_\_\_\_ Number of Abortions? \_\_\_\_\_ Number of Miscarriages? \_\_\_\_\_ Number of Live Births? \_\_\_\_\_

Date of last pap test? \_\_\_\_\_ Normal / Abnormal Date of last mammogram? \_\_\_\_\_ Normal / Abnormal

HOSPITAL ADMISSIONS <i>not including pregnancies</i>	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL PRESCRIPTION MEDICATIONS YOU ARE NOW TAKING	ALL OVER THE COUNTER MEDICATIONS & SUPPLEMENTS
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ALLERGIES / REACTION / WHEN	VACCINES YEAR OF LAST	TEST / EXAM	YEAR	TEST / EXAM	YEAR
	Tetanus/TD	Rectal / Stool		TB Test	
	Influenza (flu)	Cholesterol		EKG	
	Pneumonia	Eye Exam		Colonoscopy	
	Hepatitis	Dental Visit			

## INSURANCE & BILLING INFORMATION

Name of Person Responsible for Bill: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Laboratory to be used as required by your insurance - if known: \_\_\_\_\_