Urgent Care of Freehold

Registration Form

DATE: _____

PLEASE PRESENT YOUR DRIVERS LICENSE & INSURANCE CARD AT TIME OF CHECK-IN.
SETTLEMENT OF PATIENT COPAY OR SELF PAY BALANCES ARE DUE AT TIME OF SERVICE.
PLEASE PRINT CLEARLY ALL INFORMATION!

TYPE OF VISIT: ☐ Insurance ☐ Self-Pay ☐ On-the-Job injury ☐ Other

PATIENT NAME: _____ SEX: ☐ M ☐ F

Date of Birth: _____ SS#: _____ AGE: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

ADDRESS: _____ TOWN/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____ Primary Care Physician: _____

EMPLOYER: _____	INSURED'S NAME: _____
ADDRESS: _____	INSURED'S DOB: _____
TOWN/CITY/ZIP: _____	RELATION TO PATIENT: _____
PHONE #: _____	INSURED'S PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ PHONE NUMBER: _____

HOW DID YOU FIND OUT ABOUT US?

☐ Drive by/Signage ☐ Insurance Company ☐ Friend/Relative/Co-Worker

☐ Physician Referral (Name: _____) ☐ Advertising (Specify: _____)

Preferred Pharmacy: (Name and Location)

Urgent Care of Freehold

3681 US Highway 9 North, Freehold, New Jersey 07728
Telephone 732.863.7100 Fax 732.863.7001

PATIENT HISTORY FORM

All Allergies: ☐ No Known Allergies

1) _____ Reaction: _____
2) _____ Reaction: _____
3) _____ Reaction: _____

Last Physical Was Done: _____

All Medications: ☐ No medications

1) _____ For: _____
2) _____ For: _____
3) _____ For: _____
4) _____ For: _____
5) _____ For: _____
6) _____ For: _____

Medical Conditions: _____

Drug Usage:
☐ Never
☐ Occasionally Use: _____
☐ Quit: _____

Alcohol:
☐ No Alcohol
☐ Rare Drinker
☐ Social Drinker
☐ Every Day Drinker
☐ Other : _____

Smoking:
☐ Never Smoked
☐ Former Smoker Quit: _____
☐ Smokes ____ pack a Day/Week

Living:
☐ Alone ☐ With Family ☐ Homeless
☐ With Partner ☐ Assisted Living ☐ School

Last Known Menstrual Period:
☐ Currently
☐ ____ weeks ago
☐ Pregnant for ____ weeks
☐ Menopausal since ____
☐ Hysterectomy in ____
☐ Other _____

Employment Status:
☐ Homemaker
☐ Student
☐ Employed
☐ Unemployed
☐ On Disability
☐ Retired

Number of Children:
☐ No children
☐ ____ of my own
☐ ____ Adopted
☐ ____ Step Children

Last Tetanus Shot:
☐ Don't Remember
☐ ____ Years ago
☐ ____ Months ago
☐ Never

Last Flu Shot:
☐ Don't Remember
☐ ____ Years ago
☐ ____ Months ago
☐ Never

Last Pneumonia Shot:
☐ Never ☐ ____ Year ☐ Don't Remember

Diet:
☐ Healthy
☐ Unhealthy
☐ Working on it

Exercise:
☐ None
☐ Sporadic
☐ ___ x a week
☐ Daily

Sleeping:
☐ No sleeping problems
☐ Occasional sleeping problems
☐ Have sleeping problems

Caffeine:
☐ Never
☐ Occasional
☐ ___ cups tea/day
☐ ___ cups coffee/day
☐ ___ cups soda/day

Past Medical History: (You Or Your Family)

☐ Coronary Artery Disease
☐ Manic Depression
☐ Multiple Sclerosis
☐ Stroke: _____
☐ Cancer: _____
☐ Others:

☐ Alzheimer's
☐ Depression
☐ Hypertension
☐ Schizophrenia
☐ Parkinson's

☐ Seizures
☐ Epilepsy
☐ Migraine
☐ Allergies
☐ Asthma

☐ Diabetes I/II
☐ Hyperthyroidism
☐ Sickle Cell Anemia
☐ Cystic Fibrosis
☐ Kidney Disease

☐ ADHD
☐ COPD
☐ TB
☐ Alcoholism
☐ Osteoporosis

Is Your Mother:
☐ Alive with no problems
☐ Alive with medical problems
☐ Deceased due to _____

Is Your Father:
☐ Alive with no problems
☐ Alive with medical problems
☐ Deceased due to _____

List Previous Hospitalizations/Surgeries/Serious Illnesses or Injuries: When?

_____ _____
_____ _____
_____ _____

FOR CHILDREN:
Are immunizations up to date? _____
Is there a smoker in the family? _____
If child attends day care, name of daycare: _____

Patient Name: _____
Date of Birth: _____
What problem brings you to the doctor?
_____

Urgent Care of Freehold 3681 US Highway 9 North, Freehold, New Jersey 07728
Telephone 732.863.7100 Fax 732.863.7001

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & PATIENT CONSENT FORM

I UNDERSTAND THAT, UNDER THE Health Insurance Portability & Accountability Act of 1996 (" HIPPA ") , I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Obtain payment for third-party payers.

3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I authorize you to release information in following ways:

1. Personal cell phone # _____ E-mail address _____

2. Leave a message on answering machine regarding....

Test results	Yes ☐	No ☐
Insurance and Billing	Yes ☐	No ☐
Patient follow up care	Yes ☐	No ☐

contact you by e-mail regarding....

Test results	Yes ☐	No ☐
Insurance and Billing	Yes ☐	No ☐
Patient follow up care	Yes ☐	No ☐

3. Give information about my care to _____ Phone # _____,
(please print name) (name given must be 18 years of age or older)
in the event that I am not available for the information to be given to me.

4. May we contact you by e-mail address for patient surveys, patient educational materials and/or promotional offers? Yes ☐ No ☐

I have been informed by you, have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may contact the MediCenter office at any time to obtain a current copy of Notice of Privacy Practices.

I understand that I may request in writing how my privacy information is used or disclosed to carry out treatment, payment or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name _____

Signature _____ Relationship to patient _____
(if other than self, such as a minor)

Date _____

Urgent Care of Freehold

Financial Policy

PLEASE KNOW YOUR INSURANCE:

WE STRONGLY URGE YOU TO FAMILIARIZE YOURSELF WITH THE BENEFITS AND EXCLUSIONS OF YOUR INSURANCE CONTRACT. WE PARTICIPATE WITH MANY INSURANCE PLANS AND EACH HAS ITS OWN INDIVIDUAL CLAUSES.

OUR PRACTICE CANNOT GUARANTEE THAT ALL SERVICES/TESTING PROVIDED WILL BE COVERED. ANY DENIED/REJECTED SERVICE WILL BE BILLED TO THE PATIENT.

YOU WILL BE RESPONSIBLE FOR ALL FEES INCURRED AT THE TIME OF YOUR VISIT IF THERE ARE ANY PROBLEMS WITH YOUR COVERAGE OR ARE DECLINED PAYMENT BY YOUR INSURANCE CARRIER. **THESE FEES INCLUDE, BUT ARE NOT LIMITED TO, YOUR CO-INSURANCE, DEDUCTIBLE AND COPAY.**

YOU WILL ALSO BE RESPONSIBLE FOR ANY CHARGES INCURRED AT THE TIME OF YOUR VISIT IF THIS DATE PRECEDES THE EFFECTIVE COVERAGE DATE OR IF POLICY IS NO LONGER IN EFFECT.

WE WILL FILE YOUR INSURANCE CLAIM FOR THE PATIENT AND WAIT UP TO 60 DAYS FOR THAT PORTION OF THE PAYMENT. IF IT IS NOT RECEIVED WE WILL SEND THE BILL TO THE PATIENT. IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE COMPANY. YOU ARE THE INSURED.

FOR ALL PATIENTS:

IN THE EVENT THAT MY ACCOUNT BECOMES DELINQUENT FOR MORE THAN 30 DAYS, I ALSO AGREE TO PAY A FINANCE CHARGE OF **$5.00 PER MONTH** ON ANY BALANCE DUE, AS WELL AS A **$50.00 COLLECTION FEE**, COURT COSTS, ATTORNEY FEES AND INTEREST FEES ACCRUED WITH THE COLLECTION OF THIS ACCOUNT.

SELF PAY PATIENTS: YOU ARE AGREEING TO PAY FOR THE SERVICES TODAY.

THIS OFFICE DOES NOT ALLOW CHARGEBACKS ON ANY CREDIT CARDS

NAME OF POLICY HOLDER _____

RELATIONSHIP IF DIFFERENT FROM HOLDER _____

X_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE_____