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:

Emergency Contact: Phone: Relation to Patient:

E-mail: Pharmacy: City:

Employer Name

Employer Address

Employer Phone Number :

Father's Name (if patient is minor): Date of Birth:

Father's Address: Phone No:

Mother's Name (if patient is minor): Date of Birth:

Mother's Address: Phone No:

Active Military: Yes No Maiden Name:

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:

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 acknowledgment state reasons why efforts made to obtain acknowledgment.

PERMISSION TO DISCLOSE MEDICAL INFORMATION TO ANOTHER

With regard to my/my child's medical condition and medical records, I give permission to the Staff of Primary Care Associates of NJ, 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 in writing. You may, at any time, revoke any and all designees. Other doctors/medical entities need not be listed.

Name: Relationship:

Name: Relationship:

Name: Relationship:

Patient/Guardian Signature: Date:

07/2024

How did you hear about us? (please circle all that apply)
Patient Newspaper 'Welcome Wagon' Physician_____
Other: (please explain) _____

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

Name:	Sex:	Date of Birth:	Marital Status:
Race:	Ethnicity:		

FAMILY HISTORY

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

Mother:	Father:
Sister(s):	Brother(s):

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	Exercise? Y / N	**MALES:** Prostate Trouble Y / N
		Type?	Type:	Premature Ejaculation? Y / N
Coffee / Tea / Soda ____cups/ day			Times/week:	Difficulty attaining / sustaining
			Min/time:	erection? Y / N

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 *not including pregnancies*	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

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

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			