

# Montville Family Practice Associates

## PATIENT INFORMATION

Do you have a Living Will or Advanced Directive? Yes \_\_\_\_\_ No \_\_\_\_\_  
 (If yes, please supply our office with a copy)

PATIENT INFORMATION					
Patient's Last Name:		First:	MI:	Social Security Number	
Street Address:		City:		State:	Zip:
Home Phone Number:	Cell Phone Number:		Date of Birth:	Marital Status	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Employer Name:	Address:	City:	State:	Zip:	Occupation:      Work Phone Number:

RESPONSIBLE PARTY (if patient is under the age of 18)					
Person responsible for bill (if patient is under age 18)			Social Security Number:		Date of Birth:
Street Address: (If different from above address)		City:	State:	Zip:	Home Phone Number:      Cell Phone Number:
Employer Name:	Address:	City:	State:	Zip:	Occupation:      Work Phone Number:

INSURANCE INFORMATION					
Policyholder Name:		Social Security Number:		Date of Birth:	
Street Address:		City:		State:	Zip:
Primary Insurance Company		Policy Number:		Group Number:	
Patient's Relationship to Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Secondary Insurance Company		Policy Number:		Group Number:	
Patient's Relationship to Policyholder: <input type="checkbox"/> Other <input type="checkbox"/> Spouse <input type="checkbox"/> Child					

IN CASE OF EMERGENCY		
Emergency Contact Name:		Relationship to Patient:
Home Phone:	Cell Phone:	Work Phone:

### AUTHORIZATION TO PAY INSURANCE BENEFITS/CONSENT FOR TREATMENT

I hereby authorize payment directly to the physician responsible for my care. I understand that I am financially responsible to my physician for all fees incurred and for fees not covered by this authorization. I authorize the release of my medical information to my third party payer in order to obtain payment. I hereby authorize Montville Primary Care to release any medical information in the course of my examination or treatment. I understand that payment is expected at rendering of service unless other arrangements have been made. I hereby consent to medical treatment for my present condition or injury and for any illness or injury incurred at any time after the date noted below. I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of service.

\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Date:

HEALTH HISTORY

Montville Primary Care Physicians
137 Main Road Suite 200 Montville, NJ 07045

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Please check if you have had any of the illnesses below:

- Scarlet fever, Small pox, Pneumonia, Migraine headache, Diabetes, Nervous breakdown, Arthritis, Polio, Rheumatic fever, High blood pressure, Hay fever, Food/Drug Poisoning, Bursitis, Sciatic, Meningitis, Low blood pressure, Asthma, AIDS, Cancer, Anemia, Bone/joint disease, Broken bones, Hives, Infections, Epilepsy, Jaundice, Gonorrhea/Syphilis, Recurrent dislocations, Eczema, Tuberculosis, Diphtheria, Neuritis, Concussion/Head Injury, Other: \_\_\_\_\_

Have you ever had surgery on any of the following:

- Tonsils, Appendix, Gallbladder, Uterus, Ovary, Hemorrhoids, Upper Extremity, Lower Extremity

Have you ever had a blood transfusion?
Have you ever had a hernia repaired?
Any other operations?
List any family illnesses?

REVIEW OF CHRONICALLY OCCURRING SYMPTOMS

Please check if you have had any of the following:

- Eye disease, Fainting spells, Blood in urine, Hemorrhoids, Black, tarry stool, Eye injury, Convulsions, Difficulty in urinating, Rectal bleeding, Bowel disease, Ear disease, Dizziness, Narrowed urinary stream, Parasites, Changes in bowel pattern, Ear injury, Headaches, Stomach trouble, Worms, Constipation, Impaired hearing, Night sweats, Ulcer, Colitis, Diarrhea, Nose problem, Thyroid problem, Indigestion, Appendicitis, Mouth problem, Enlarged goiter, Changes in eating habits, Liver disease, Throat problem, Skin disease, Abnormal thirst, Chest pain, Enlarged glands, Varicose veins, Kidney disease, Fluttering heart, Cough, Swelling of hands, Kidney stones, Shortness of breath, Spitting up blood, Swelling of feet

Have you ever had any of the following tests? (list dates)

- EKG, Bloodwork, X-Rays, Bone density, Colonoscopy

SOCIAL HISTORY

Do you have? Alcohol problem, Drug problem
Do you smoking? Yes, No, How many packs?

Female Information

Age of onset of menstrual cycle, Date of last period
Are you pregnant now? Yes, No, Have you ever been pregnant? Yes, No, How many children do you have?

ALLERGIES

Are you allergic to: Penicillin, Sulfa Drugs, Aspirin, Codeine, Morphine, Mycins, Tetanus, Antitoxins, Serums, Any other drugs?, Any foods?

MEDICATIONS

Please list any medications that you are presently taking:
Are you on a prescribed diet? Height: Weight: Right handed? Left handed?

PATIENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_





MONTVILLE FAMILY PRACTICE ASSOCIATES  
 137 Main Road Suite 200  
 Montville, NJ 07045  
 Phone: 973-402-0025 Fax: 973-402-0508

**REQUEST FOR MEDICAL RECORDS**

**\*\*I, \_\_\_\_\_, do hereby consent Montville Family Practice Associates to obtain information from my medical records relating to my treatment. This release is to be limited to the specified reports within the specified dates of treatments I have indicated below. I understand that this consent shall operate as a complete release of liability to:**

\_\_\_\_\_  
 (hospital or medical facility name), and its employees for the release of the information as specified below.

**\*\*PATIENT NAME:** \_\_\_\_\_

**\*\* DOB:** \_\_\_\_\_

**TREATMENT DATES NEEDED:** \_\_\_\_\_

**REPORTS NEEDED:** \_\_\_\_\_

**SPECIAL INSTRUCTIONS:** \_\_\_\_\_

**I understand that once my health information is released to the above recipient, your hospital or medical facility cannot guarantee that the recipient will not disclose my health information to a third party. I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorized,**

\_\_\_\_\_,  
 (hospital or medical facility name), to disclose my health information in the manner described above.

**\*\* \_\_\_\_\_**  
 Patient Signature

\_\_\_\_\_  
 Date

**If the individual is a minor or is otherwise unable to sign this authorization, please complete the information below:**

\_\_\_\_\_  
 Signature of Authorized Legal Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

Consent to request medical records



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**INSURANCE COMPANIES WILL NOT PAY PROVIDERS  
IF CLAIMS ARE NOT SUBMITTED WITHIN 60 DAYS.  
THEREFORE, IT IS IMPORTANT FOR OUR PATIENTS  
TO PROVIDE THE CORRECT INSURANCE  
INFORMATION AT THE TIME OF SERVICE.**

**IF I, \_\_\_\_\_, DO NOT PROVIDE THE  
CORRECT INSURANCE AT THE TIME OF VISIT I AM  
FULLY RESPONSIBLE FOR THE CHARGES.**

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE



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**PERMISSION TO RELEASE MEDICAL INFORMATION**

I, \_\_\_\_\_, give Montville Family Practice Associates permission to  
release any medical information requested by \_\_\_\_\_.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**



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RECEIPT OF PRIVACY PRACTICE NOTICE  
WRITTEN ACKNOWLEDGEMENT FORM

I, \_\_\_\_\_, am aware that a copy of the Notice of Privacy Practices is available for my review at the office's front reception. I have read and understand the terms and conditions.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**\*FOR YOUR CONVEINENCE, OUR OFFICE CAN MAKE A COPY OF THIS DOCUMENT UPON REQUEST\***



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**REQUEST FOR MEDICAL RECORDS**

**TO:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:**

**MONTVILLE FAMILY PRACTICE ASSOCIATES  
137 MAIN ROAD SUITE 200  
MONTVILLE, NJ 07045**

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**DATE OF BIRTH**