MANALAPAN MEDICAL CENTER

General Patient Information

Last Name: _____ First Name: _____

Home Tel: _____ Work Tel: _____

Cell Tel: _____ Other Tel: _____

Sex (Circle One): Male Female E-Mail Address: _____

Address: _____

_____

Date of Birth: _____/_____/_____ Occupation: _____

S.S.# _____

Family Doctor: _____ Tel: _____

Emergency Contact: _____

Relationship to patient (Circle One): Spouse Parent/Guardian Other: _____

Tel: _____

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

Insured Name: _____

Relationship to patient (Circle One): Self Spouse Parent/Guardian

Medical History:

Medications

(Please list any medications you are currently taking)

Medication	Dosage	Notes

Do you take calcium?(specify dose).

Do you take vitamin D ?(specify dose).

Do you take multivitamins?(specify dose)

Do you take any daily, weekly or monthly medications for osteoporosis? (specify name).

Do you take any intravenous medications every 3 months or once a year for osteoporosis?

Patient's Name_____ Date:_____

Past Medical History / Family History
(Please check any of the following conditions that apply to yourself or your family)

Family	Self		Family	Self	
		Diabetes			Heart Problems
		High Cholesterol			Asthma/COPD
		Hypertension			Cancer
		Osteoarthritis			Thyroid problems
		GERD/Acid Reflux			Osteoporosis :have you ever been tested for osteoporosis, when and where was your last test done
		Fractures			
If other, please specify:					

Allergies
(Please check in a box any of the following allergies that apply to you)

☐	Aspirin	☐	Seasonal
☐	Dust Mites	☐	Sulfa Drugs
☐	Penicillin	☐	**NO KNOWN ALLERGIES**
If other, please specify:			

Review of Systems
(Please mark "YES" or "NO")

yes	no	Recent weight changes	yes	no	Chest pain or tightness
yes	no	Blurred or Double Vision	yes	no	Fainting/dizziness
yes	no	Difficulty Hearing	yes	no	Irregular Heartbeat
yes	no	Urinary retention/incontinence	yes	no	Skin problems/wounds
yes	no	Chronic or Frequent cough	yes	no	Nausea or vomiting
yes	no	Shortness of Breath	yes	no	Abdominal pain or heartburn
yes	no	Snoring	yes	no	Impotence
yes	no	Fever/night sweats	yes	no	Depressed or Sad
yes	no	Bleeding or bruising easily	yes	no	Diarrhea/constipation
yes	no	Frequent or Chronic Headaches	yes	no	Nervous or Anxious
yes	no	Hair loss	yes	no	Sleep problems
yes	no	Seizures	yes	no	Painful or swollen joints
yes	no	Memory Problems	yes	no	Back or neck pain
yes	no	Difficulty swallowing	yes	no	Difficulty or pain with walking
yes	no	Rashes or Itching	yes	no	Fatigue/weakness
yes	no	Falls	yes	no	Menstrual problems/age of menopause:

Social History

(Please check in a box if any of the following apply to you)

☐	alcohol use	☐	illegal drug use
☐	tobacco use	☐	**other:**

Surgical History

(Please list any surgeries you have underwent in the past)

Procedure	Year	Notes

I,_____ hereby authorize to disclose my personal health related information to the following individuals:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Patient's Signature

Date

Manalapan Medical Center, PA

345 Route 9 South
Manalapan, NJ
07726

******We must have the above information BEFORE you may see the doctor******

I assign directly to Manalapan Medical Center all medical insurance benefits. I understand that in the event the charges are applied to my in-network insurance deductible or coinsurance, or charges are not covered, or if my insurance is invalid, I am responsible for all balanced due.

I authorize any holder or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please ***print*** name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

HIPAA PRIVACY

Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice"), I acknowledge and agree that I have received, read and understand the Notice of the Notice Privacy Practices for review and to keep for my records on the date identified below.

I understand that Manalapan Medical Center may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, exam information and/or type of products provided) to another party to permit Manalapan Medical Center to perform its administrative duties, provide me with medical care services and products, process my vision benefit claims and communicate with me regarding medical care services provided by Manalapan Medical Center (for example, mailings of exam reminders or information about services / products provided by Manalapan Medical Center).

I can be assured that this location does not sell my personal health information of any kind to a third party for such party's own use. I authorize the Location to submit my medical benefit claims to my plan sponsor or health plan to receive reimbursement directly for the medical services and products that I have received from Manalapan Medical Center.

_____ _____

Patient Signature or Patient's legal Representative Date

Effective: 09-23-13