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 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 check if any of the following apply to you)

	Recent weight changes		Chest pain or tightness
	Blurred or Double Vision		Fainting/dizziness
	Difficulty Hearing		Irregular Heartbeat
	Urinary retention/incontinence		Skin problems/wounds
	Chronic or Frequent cough		Nausea or vomiting
	Shortness of Breath		Abdominal pain or heartburn
	Snoring		Impotence
	Fever/night sweats		Depressed or Sad
	Bleeding or bruising easily		Diarrhea/constipation
	Frequent or Chronic Headaches		Nervous or Anxious
	Hair loss		Sleep problems
	Seizures		Painful or swollen joints
	Memory Problems		Back or neck pain
	Difficulty swallowing		Difficulty or pain with walking
	Rashes or Itching		Fatigue/weakness
	Falls		Menstrual problems/age of menopause:

Social History
(Please check 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

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 the Location 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 the Location 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 the Location (for example, mailings of exam reminders or information about services / products provided by the Location).

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 the Location.

_____ _____

Patient Signature or Patient's legal Representative Date

MANALAPAN MEDICAL CENTER

I,_____ hereby authorize to disclose my personal health related

information to the following individuals:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Patient's Signature _____

Date: _____ Effective: 08.30.18