

Patient Insurance Information

Today's Date _____

Patient's Name (Last Name, First Name)		Birth Date	Social Security # - -
Patient's Address Street City, State, Zip Code		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> Other	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
Name of Insurance Company: ID / Policy #: Co-Pay Amount: \$		Phone Numbers <input type="checkbox"/> Home : <input type="checkbox"/> Work : <input type="checkbox"/> Cell :	
Policy Holder's Name		Please check all boxes above where we can leave a message.	
Policy Holder's Birth Date	Policy Holder's Social Security # - -	E-Mail Address (not required)	

Secondary Insurance Information (if any)

Secondary Insurance Company ID / Policy #: Name of Policy Holder	Birth Date	Social Security # - -
--	------------	--------------------------

Guardian Information (if Patient is a Minor)

Guardian Name	Birth Date	Social Security # - -
Guardian Address - Check here if same as patient's <input type="checkbox"/> Street Address City, State, Zip Code	Home Phone #: Work Phone # : Cell Phone # :	

Please read, sign and date the following:

By signing below, you agree that all insurance payments be made directly to Family Health Center of Montclair and furthermore that you authorize the release of medical records or information to your insurance company, their agents and referring doctors for the purpose of processing insurance claims on your behalf.	
Signature of Patient or Guardian _____	Date _____

Patient Information Form

Today's Date _____

Please provide information on your Medical History as requested below. Please print clearly.

Brief Medical History

Patient's Name (Last Name, First Name, Middle Initial)	Birth Date / /	Social Security # - -
Occupation	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Allergies (please list all foods and medications you have an allergy to):		
Medical / Surgical History (please list any specific conditions and/or surgeries you have had):		
Pills / Medications (please list all medications that you are currently taking):		
Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you wear a seat belt? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a gun in your home? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have an Advance Directive / Living Will? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have an Organ Donor card? <input type="checkbox"/> No <input type="checkbox"/> Yes	How did you hear about this office?	
Please list Name, Address and Phone Number of nearest relative or friend in case of Emergency:		
Name	Phone #	
Street Address		
City, State, Zip Code		
Please list names of other family members who are Patients in this office:		

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party payers; and
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I 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 this organization has the right to change its *NOTICE OF PRIVACY PRACTICES* from time to time and that I may contact this organization at any time at the address below to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name	Relationship to Patient
Signature of Patient or Legal Representative	Date

Acknowledgement Also Covers Children Listed Here

Office Use Only

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason
------	----------	--------