TOVBA CARE MEDICAL PC **Date_____**

Patient's Name:_____Date of Birth:_____ Chart #_____

Patient's Gender: __M __F **Marital Status: ___Single ___ Married ___Partnered ___Widowed ___Divorced**

Address:_____City:_____State____Zip_____
Telephone: Home:_____ Cell:_____ Other:_____

SS #_____E Mail Address:_____

Employer:_____ Employer Tel #_____
Employer Address:_____City_____State____Zip_____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

__Physician __Family Member __Friend ***Name of Referring Person*****_____**
__Internet ___Website __Facebook ***Other*****_____**

INSURANCE INFORMATION

Primary Insurance: _____ Are you the Policy Holder? __Yes __No

Is this a managed care Medicare or other Program (HMO) ___Yes ___No

Insured Information:
Subscriber Name: _____ Relationship: ___Self ___Spouse ___Child ___Other
Phone#_____Sex __Male __Female DOB ___ /____ / _____
Address: _____Policy#_____ Group #_____
Employer:_____

Secondary Insurance: _____ Are you the Policy Holder? __Yes __No

Is this a managed care Medicare or other Program (HMO) ___Yes ___No

Insured Information:
Subscriber Name: _____ Relationship: ___Self ___Spouse ___Child ___Other
Phone#_____ Sex __Male __Female DOB ___ /____ / _____
Address: _____Policy#_____ Group #_____
Employer:_____

What is the Primary Reason for Today's Visit? _____
How Long Has This Been Bothering You? _____ days weeks months years

Please Read and Sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_____ _____ _____
Signature of patient or representative Print Name Date

Medical History

Please Circle if You Have Had Any of the Following:

AIDS/HIV
Allergy to Anesthetic
Anemia
Angina
Arthritis
Artificial Heart/Valve/Joint
Asthma
Back Problems
Bladder Problems
Bleeding Disorders
Cancer, Type: _____
Chemical Dependency
Chest Pain
Cholesterol
Chronic Diarrhea
Circulatory Problems
Diabetes, Type: _____
Ear Problems
Epilepsy
Eye Problem
Fainting
Frequent Infections
Gout
Headaches
Hearing Problems
Heart Disease
Hemophilia
Hepatitis or Jaundice
High Blood Pressure
Immune Disorders
Kidney Problems
Liver Disease
Low Blood Pressure
Neurological
Neuropathy
Phlebitis
Psychiatric Care
Radiation Treatment
Rash
Respiratory Disease
Rheumatic Fever
Shortness of Breath
Sinus Problems
Skin Cancer
Special Diet
Stroke
Swelling in Ankles, Feet
Swollen Neck/Glands
Thyroid
Tired Feet
Tuberculosis
Ulcers - Stomach, Other:_____
Varicose Veins
Venereal Disease
Weight Loss, unexplained
OTHER_____
_____

SURGICAL HISTORY

Please Provide Your Surgical History:

Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

By signing at the bottom of this page, you have read and understood the following:
Treatment Consent: I hereby Consent and give my permission to the doctor (and doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Please Read and Sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_____ _____ _____
Signature of patient or representative Print Name Date

SOCIAL HISTORY:

Do You Smoke ___Yes __No If yes how many packs per day ____ For How Long _____

Alcohol Use ___Yes everyday (5-7 days/week) __Yes Occasionally/socially __No/rarely
Substance Abuse ___Yes, I have a current substance abuse problem.
Please specify: _____
__No, I have never had a substance abuse problem.
Occupation: _____Does it involve mostly __standing __sitting
Exercise: ____ I do not exercise regularly ____Yes, I do the following regular exercise:
_____

FAMILY HISTORY: PLEASE INDICATE WHICH FAMILY MEMBER

___Alzheimer's _____ ___Depression _____
___Arthritis _____ ___Diabetes _____
___Bleeding disorders _____ ___Emphysema _____
___Blood clot _____ ___Heart Disease _____
___Cancer _____ ___High Blood Pressure _____
___Cataracts _____ ___Neurological _____
___Circulation Problems _____ ___Strokes _____
___Other (please specify_____ ___ Other (please specify) _____

Review of Systems: If any of the following apply to you, please check off

Cardiovascular:	__fever	__fainting	__ chest pain/pressure	__ leg swelling	__ cold hands/feet	
	__ leg pain while walking	__ heart palpitations	__ vascular disease	__ valve problems	__ None	
Ears/Nose/Throat:	__ sinus problems	__ polyps	__ deafness		__ None	
Endocrine:	__ diabetes	__ thyroid problems			__ None	
Eyes:	__ cataracts	__ glaucoma	__ blindness		__ None	
Gastrointestinal:	__ abdominal pain	__ increased appetite	__ heartburn	__ vomiting	__ blood in stool	
	__ trouble swallowing	__ decreased appetite	__ diarrhea	__ ulcer	__ constipation	__None
Genitourinary:	__ blood in urine	__ hesitancy	__ incontinence	__ increased urgency		
	__ decreased frequency	__ excessive urination	__ kidney disease	__ kidney stones	__ None	
Integumentary:	__ nail abnormalities	__ athlete's foot	__ dry, scaly skin	__ itchiness	__ keloids	__ None
Hematologic:	__ lower leg ulcers	__ clotting disorders	__ blood thinners	__ anemia	__ sickle cell	__ None
Musculoskeletal:	__ joint swelling	__ muscle weakness	__ muscle pain	__ back pain	__ neck pain	
	__ joint stiffness	__ joint instability	__ joint pain	__ sciatica	__ arthritis	__None
Neurological:	__ tingling	__ weakness	__ seizures	__ numbness		
	__ headaches	__ tremors	__ paralysis		__ None	
Respiratory:	__ chest pain	__ wheezing	__ COPD	__ coughing	__ snoring	
	__ emphysema	__ shortness of breath			__ None	

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_____ _____ _____
Signature of patient or representative Print Name Date

Ethnicity: _____

I prefer not to answer _____

Preferred language: _____

I prefer not to answer _____

Pharmacy Name: _____ **Pharmacy Phone:**_____
Pharmacy Address:_____

Privacy Information Preferences:

Can we call the phone number on file? _____**Yes** _____**No**

Can we leave voicemail on machine? _____**Yes** _____**No**

Who can we leave message with? _____**Wife** _____**Husband**_____**Other**

Name(s)_____

Vital Signs

Blood Pressure:_____/_____

Height:_____Weight:_____

Current Medications

Name:_____**Dose:**_____

Name:_____**Dose:**_____

Name:_____**Dose:**_____

Name:_____**Dose:**_____

Name:_____**Dose:**_____

Name:_____**Dose:**_____

Name:_____**Dose:**_____

Allergies

_____**No Known Allergies**

Name_____**Reaction:**_____

Name_____**Reaction:**_____

Name_____**Reaction:**_____

Name_____**Reaction:**_____

Name_____**Reaction:**_____

By signing at the bottom of this page, you have read and understood the following:
(Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practice Notice. (Medication History): I authorize the Doctor's office to retrieve my medical history.

Please Read and Sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_____ _____ _____
Signature of patient or representative Print Name Date

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -