Welcome to Affiliated Medical Associates of Morristown

PATIENT INFORMATION:

Patient's Last, First Name	**Sex** □ **M** □ **F**	**Birth Date** __/__/__ **Age** _____	**Last 4 Digits to Social Security #:**
Residence Address City State Zip Code			**Marital Status:** □ **Other** □ **Single** □ **Married** □ **Widowed** □ **Divorced**
Home Phone ( ) -	**Cell Phone** ( ) -	**Work Phone** ( ) -	**Parent's Phone # If Student** ( ) -
Email Address:	**Name/Address of Employer**		**Ref/ Primary Care Dr.** **Dr. Tel #**
Emergency Contact (Last & First Name and Phone number):			**Pharm:** **Pharm Tel #**

INSURANCE INFORMATION: ***Please give your insurance card(s) to the office staff to be copied***

PRIMARY INSURANCE: **ID NUMBER:**

Subscriber's Name - If Other Than Patient

Name **Birth Date** __/__/__ **Relationship** □ **Other** □ **Spouse** □ **Parent**

SECONDARY INSURANCE: **ID NUMBER:**

Subscriber's Name - If Other Than Patient

Name **Birth Date** __/__/__ **Relationship** □ **Other** □ **Spouse** □ **Parent**

WORKERS' COMPENSATION INSURANCE: **CLAIM NUMBER:**

OR MOTOR VEHICLE INSURANCE: **CLAIM NUMBER:**

Person to Contact: **Phone Number:** ( ) -

Acknowledgement of Receipt of Privacy Notice and Assignment of Benefits

I have been presented with a copy of Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information _____

In addition, I authorize payment of medial benefits, through both private health insurance and Medicare or Medicaid; to Affiliated Medical Associates of Morristown for any services furnished to me by their physician(s).I authorize Affiliated Medical Associates to initiate appeals on my behalf. I understand that I am financially responsible for any amount not covered by my contract(s). ***It is your responsibility to determine if Affiliated Medical is a participating provider in your network and that you will be responsible for any financial liabilities incurred.***

_____ (Signature) ____/____/____ (Date)

If patient is under 18 years of age a parent must sign.

NAME: _____

Reason for Visit: _____

Please check items below if you have or had a personal history of the illness

0 Anemia	**0 Cancer**	**0 Gonorrhea**	**0 Liver Disease**	**0 Osteomyelitis**
0 Arteritis	**0 Colds – Frequent**	**0 Heart Disease**	**0 Lung Disease**	**0 Pneumonia**
0 Arthritis	**0 Diabetes, Type I**	**0 HIV – Aids**	**0 Lyme Disease**	**0 Rheumatic Fever**
0 Asthma	**0 Diabetes, Type II**	**0 Hives**	**0 Malaria**	**0 Meningitis**
0 Blood Disease	**0 Eczema**	**0 High Blood Pressure**	**0 Low Blood Pressure**	**0 Syphilis**
0 Boils – Frequent	**0 Endocarditis**	**0 Infections-Frequent**	**0 Mental Illness**	**0 Tuberculosis**
0 Bursitis	**0 Genital Disease**	**0 Kidney Disease**	**0 Migraine**	**0 Thyroid Disease**

0 OTHER Please explain any personal history of other illnesses: _____

DO YOU HAVE A HEART MURMUR? 0 Yes ____ 0 No ____ WHEN WAS YOUR LAST DENTAL EXAMINATION? _____

PREVIOUS HOSPITALIZATIONS **INCLUDE DATE - (YEAR ONLY)**

_____

_____

MEDICATIONS	**DOSAGE**

ALLERGIES	**ADVERSE REACTIONS**

FAMILY HISTORY OF ILLNESSES: **Please check items below if you have a family history of the illness**

0 ASTHMA	0 HEART DISEASE	0 LUNG DISEASE	0 SEIZURES
0 BLOOD DISEASE	0 HIGH BLOOD PRESSURE	0 LUPUS	0 STROKE
0 CANCER	0 JOINT DISEASE	0 MENTAL ILLNESS	0 SUICIDE
0 DIABETES	0 KIDNEY DISEASE	0 RHEUMATOID ARTHRITIS	0 TUBERCULOSIS

0 OTHER Please explain any family history of other illnesses:

HAVE YOU HAD OR BEEN EXPOSED TO ANY OF THE FOLLOWING: **Please check *YES or NO* in the space provided**

CHICKEN POX	☐ YES ☐ NO	GONORRHEA	☐ YES ☐ NO	SYPHILIS	☐ YES ☐ NO
COLD SORES	☐ YES ☐ NO	HIV	☐ YES ☐ NO	TUBERCULOSIS	☐ YES ☐ NO
GENITAL HERPES	☐ YES ☐ NO	MENINGITIS	☐ YES ☐ NO		

SOCIAL HISTORY:

HOW MUCH ALCOHOL DO YOU CONSUME IN A WEEK? _____ HOW MUCH DO YOU SMOKE IN A WEEK? _____

HAVE YOU USED INTRAVENOUS DRUGS? 0 YES 0 NO IF YES, LAST TIME _____

HAVE YOU HAD ANY SEXUAL CONTACT WITH PROSTITUTES 0 YES 0 NO

HAVE YOU HAD ANY SEXUAL CONTACT WITH PARTNERS OF THE SAME SEX? 0 YES 0 NO

DO YOU HAVE ANY PETS (Include fish, birds, reptiles)? ☐ Yes ☐ No What Kind?_____

LIST CONTINENTS YOU HAVED VISITED (INCLUDE YEAR) Africa, Antarctic, Asia, Australia, Europe, North America, South America

1._____ 2._____ 3._____

4._____ 5._____ 6._____

VACCINATIONS YOU HAVE RECEIVED: Please check the appropriate answers - list year obtained in space provided

0 TB Tuberculosis _____ 0 FLU _____ 0 PNEUMONIA _____