ATLANTIC MEDICAL ASSOCIATES
PATIENT INFORMATION SHEET

PATIENT NAME:	**SOCIAL SECURITY #:**	**DATE OF BIRTH:**
MAILING ADDRESS:		
EMAIL ADDRESS:		
HOME PHONE #:	**CELL/PAGER #:**	**WORK PHONE #:**
EMPLOYER:		
EMPLOYER'S FULL ADDRESS:		
EMPLOYER'S PHONE #:	**PHARMACY-Location & Phone #:**	

REASON FOR VISIT – WAS THIS INJURY RELATED TO: (CHECK ONE):

WORK RELATED?	**AUTO RELATED?**	**HOME RELATED?**

INSURANCE INFORMATION

COMPANY NAME:	**TYPE: (CHECK ONE)** **WORKERS COMPENSATION** **MEDICAL / AUTO / HOME OWNER'S / OTHER**	
COMPANY ADDRESS:		
ID #:	**GROUP #:**	**CLAIM #:**
Subscriber Name:	**Subscriber Date of Birth:**	**Relation to Subscriber:**
COVERAGE EFFECTIVE DATE:		**DATE OF INJURY: AccidentDate**

GUARANTOR INFORMATION (FOR MINORS, SPOUSE OR GUARDIAN)

RESPONSIBLE PARTY: (FULL NAME)	**RESPONSIBLE PARTY SSN:**	**DATE OF BIRTH:**
ADDRESS:		**TELEPHONE #:**
EMPLOYER:		**RELATIONSHIP TO PATIENT:**

IN CASE OF EMERGENCY NOTIFY: NAME, ADDRESS & TELEPHONE #

HOW WERE YOU REFERRED TO OUR OFFICE? (PLEASE CHECK ONE)

PHYSICIAN (DR.)	**FRIEND/FAMILY**	**INSURANCE COMPANY**	**EMPLOYER**	**OTHER**

I give and assign you, Seaview Orthopaedic & Medical Associates, the right to ask, demand and collect and receive payment for my medical bills from such insurer or from such other sources as may be obligated for payment. I understand that the assignment of these rights by me does not obligate my physician(s) and Seaview Orthopaedic & Medical Associates to take any action to collect or receive payment from an insurer or other source and I understand that any outstanding balance that my insurance does not cover is my absolute responsibility. This responsibility can only be changed if a prior arrangement was made in writing by Seaview Orthopaedic & Medical Associates.

It is hereby understood that if I falsify any information on this sheet, the balance will then become my full responsibility deemed payable upon demand. It is hereby understood that I am responsible for all deductibles, co-payments, co-insurance and/or services not covered by my insurance plan at the time such services are rendered. It is hereby understood and agreed that I will be responsible for an administrative charge of 1% per month that may be imposed on my bill for any unpaid balance beginning thirty (30) days after receipt of services.

It is further understood and agreed that in the event Seaview Orthopaedic & Medical Associates is forced to take legal action to collect any unpaid balance, that I will be responsible for paying Seaview Orthopaedic & Medical Associates for reasonable attorney fees, costs and interest associated with any and all legal actions as a result of the unpaid balance.

Signed: Date:

Public law in the State of New Jersey mandates that a physician, chiropractor or podiatrist inform his/her patients of any significant financial interest they may have in a healthcare services. Accordingly, we wish to inform you that certain physicians do have financial interests in the following healthcare services to which we could refer out patients:

Seaview Orthopaedic & Medical Associates

Date:

Parent, Guardian, Insured Authorized Signature

_____

Witness Signature

Atlantic Medical Associates

Patient Name: _____

DOB: _____ **Date:** _____

Reason for today's visit: _____

_____

List all current medications and dosages:

Medication	Dose/Frequency	Medication	Dose/Frequency

Are you allergic to any drugs? *Circle one* Yes or No *If yes, please list those drugs below:*

Drug	Reaction (i.e. rash, hives)	Drug	Reaction (i.e. rash, hives)

Hospitalizations: _____

_____

Surgeries: _____

_____

Are you Pregnant? YES_____ NO_____

Health Maintenance
When was your last:

Tetanus _____ / _____ / _____

PAP Smear _____ / _____ / _____

Mammography _____ / _____ / _____

Colonoscopy _____ / _____ / _____

Blood Test _____ / _____ / _____

EKG _____ / _____ / _____

Chest X-ray _____ / _____ / _____

Past Medical History *(Please **circle** all that apply to you):*

Diabetes	Heart Disease	High Blood Pressure	Heart Attack
High Cholesterol	Asthma	Stomach Ulcers	Kidney Disease
Liver Disease	Lyme Disease	Rheumatoid Arthritis	Cancer
Depression	Anxiety	Emphysema	COPD
Hepatitis	Seizures	Thyroid Disease	Coronary Artery Disease
Mulitple Sclerosis	Bleeding Disorder	Congestive Heart Failure	Vascular Disease
Lupus	Tuberculosis	Weight loss/gain	Gallbladder Disease
Skin Disease	Venereal Disease	Anemia	Osteoporosis

Please list any medical conditions you may have not mentioned above:

_____

_____

_____

Family History *(Please **check** all that apply to members of your family):*

	Mother	**Father**	**Sibling**	**Children**	**Granparent**
High Blood Pressure					
Diabetes					
Bleeding Disorder					
Stroke					
Heart Disease/Attacks					
Lung Disease					
Kidney Disease					
Mental Disorder					

Please list any medical disease that a member of your family may have that is not mentioned above:_____

Social History

Please **circle** one: Single / Married / Partnered / Widowed / Divorced

- **Do you smoke?** ___ Current Smoker ___ Former Smoker ___ Never Smoked

  ___ Pipe Smoke ___ Cigar Smoker ___ Smoker, current status unknown ___ Unknown

  If yes, how much do you smoke? ___ 3 cigarettes or less per day ___ Half a pack/day
  ___ More than a pack per day

- **Do you drink alcohol?** YES NO

  If yes, how frequent? ___ Social only ___ Several times per week ___ Everyday

- **Do you or have you used illicit drugs?** YES NO

  If yes, what kind? ___ IV Drugs ___ Pills ___ Marijuana

Occupation: _____

Review of Systems

Please circle any of the following symptoms that you've experienced recently:

Constitutional

Fatigue	Fever	Night Pain	Weight loss	Weight gain

Eyes

Vision loss	Red eyes	Glasses/Contacts	Dry eyes	Blurry vision

Ears/Nose/Mouth

Sore throat	Hearing loss	Cough	Dry mouth	Nose bleed

Cardiovascular

Chest pain	Palpitations	Leg swelling	Dizziness	SOB

Respiratory

Chronic cough	Wheezing	Chest pain	Shortness of Breath (SOB)

Gastrointestinal

Heartburn	Nausea	Abdominal pain	Diarrhea	Blood in stool

Genitourinary

Burn w/urination	Urine incontin	Freq urination	Blood in urine	UTI's

Skin

Rash	Hives	Alopecia	Raynaud's	Infection

Neurological

Headache	Weekness	Dizziness	Tremor	Seizures

Psychiatric

Depression	Eating disorder	Suicidal	Panic attacks	Trouble sleeping

Endocrine

Excess sweating	Excess thirst	Freq urination	Heat intolerance	Fatigue

Hematological/Lymph

Easy bleeding	Easy bruising	Swollen glands	Night sweats	Fevers

Allergy/immune

Sinus congestion	Itchy eyes	Runny nose	Scratchy throat	Ear fullness

Patient Signature: _____ Date: _____