FirstMed Family Healthcare
Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_______________

Patient's Name (Last)____________________________ (First)______________________ (Middle)________________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _______-_____-_______ ☐ Female ☐ Male Date of Birth______/______/______

E-Mail Address____

Phone Numbers Work____________________ Home____________________

Cellular___________________

Address____

City, State, ZIP (+4)____

Employment Status ☐ Employed ☐ Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer____ Occupation____________________________

Emergency Contact Name___________________________________ Phone Number___________________

Emergency Contact Relationship to Patient____

Referring Provider Name____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)____________________ (First)______________________ (Middle)________________

Also Known As Name (Last)________________________________(First)____________________________

Social Security Number _______-_____-_______ ☐ Female ☐ Male Date of Birth______/______/______

E-Mail Address____

Phone Numbers Work____________________ Home____________________

Address____

City, State, ZIP (+4)____

Employment Status ☐ Employed ☐ Student ☐ Retired ☐ Self-Employed

Employer____ Employer Phone Number____________________

Patient Relationship to Responsible Party____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured____ Patient Relationship to Insured____________________

Insured Employer Name____

Insurance Company/Phone Number____ (______)________________

Subscriber ID (Policy Number)__________________ Group ID_________________ Copay Amount___________________

Effective Date____________________

Insured Date of Birth_______/_______/_______ Insured's Social Security Number _______-_____-_______

Insurance Company Address____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured____ Patient Relationship to Insured____________________

Insured Employer Name____

Insurance Company/Phone Number____ (______)________________

Subscriber ID (Policy Number)__________________ Group ID_________________ Copay Amount___________________

Effective Date____________________

Insured Date of Birth_______/_______/_______ Insured's Social Security Number _______-_____-_______

Insurance Company Address____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature____ ***Date***________________

244 Livingston St A, Northvale, New Jersey 07647 Phone: 201-768-1200 Fax: 201-768-4569

FirstMed Family Healthcare
MEDICAL HISTORY FORM

Name: ____ Today's Date: ___________
Last First Middle

Sex: ______M ______F ______Other Date of Birth: __/__/____ Occupation: ___________________

Marital Status: ______Married ______Single ______Divorced ______Widowed Number of Children: ______

Tobacco Use: ______Yes ______No ______Previous Use How do you consume? _______________________

How much per day/week/month? ______ How long for? ______ Date quit? ______

Alcohol Use: ______Yes ______No ______Previous Use

How much per day/week/month? ______ How long for? ______ Date quit? ______

Past Illness

Yes	No		Yes	No		Yes	No	
☐	☐	Alcoholism	☐	☐	Glaucoma	☐	☐	Osteoporosis
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease
☐	☐	Cancer/Tumor	☐	☐	Kidney Disease	☐	☐	Ulcer in GI Tract
☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	High Cholesterol
☐	☐	Drug abuse	☐	☐	Lung Disease	☐	☐	Other: ___________
☐	☐	Depression	☐	☐	Mental Illness	☐	☐	Other: ___________
☐	☐	Epilepsy/Seizures	☐	☐	Osteoarthritis	☐	☐	Other: ___________

Family History: *List any illness disease of family members*

____ ____

____ ____

Past Surgical History: *List any procedures or surgeries in the past including dates*

____ ____

____ ____

Current Medications: *Include Birth Control Pills, Vitamins, and Supplements*

____ ____

____ ____

____ ____

Allergies: ____ ____

Additional Information:

Last Mammogram: _____________ Where: _____________ Last Pap test: _____________ Gyn: ____________

Last Colonoscopy: _____________ Normal? _____________ Last Bloodwork: _____________

Vaccine Dates: Tetanus: _____________ Pneumonia: _____________ Flu: _____________ Hep B: ___________

REVIEW OF SYMPTOMS

Current Complaint: ____

Yes	No	
☐	☐	Appetite Change/Problem
☐	☐	Weight Change/Problem
☐	☐	Change in Bowel Habits
☐	☐	Sleep Change/Problem
☐	☐	Change in Activity Tolerance
☐	☐	Fatigue/Weakness
☐	☐	Fever/Chills
☐	☐	Night Sweats

Yes	No	
☐	☐	Vision Change/Problem
☐	☐	Eye Pain/Irritation/Tearing
☐	☐	Eye Redness
☐	☐	Eye/Ear Trauma
☐	☐	Hearing Change/Problem
☐	☐	Ear Pain/Discharge/Infection
☐	☐	Dizziness
☐	☐	Ringing in Ears

Yes	No	
☐	☐	Cough/Sputum
☐	☐	Respiratory Infection
☐	☐	Wheeze/Asthma
☐	☐	Chest Pain
☐	☐	Out of Breath Easily/Quickly
☐	☐	Smoking/Tobacco Use
☐	☐	Breast Lump/Swelling/Pain
☐	☐	Breast Discharge/Bleeding

Yes	No	
☐	☐	Chest Pain/Discomfort
☐	☐	Out of Breath Easily/Quickly
☐	☐	Palpitations
☐	☐	Swelling of Feet/Hands
☐	☐	Leg Pain/Cramps on walking
☐	☐	Rash/Itch/Sores/Lumps
☐	☐	Mole Size/Number Increase
☐	☐	Easy Bruising/Bleeding

Yes	No	
☐	☐	Problem with Teeth/Gums/Dentures
☐	☐	Swallowing Problem
☐	☐	Nausea/Vomiting
☐	☐	Abdominal Pain
☐	☐	Heartburn/Indigestion
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Yellow Eyes/Skin

Yes	No	
☐	☐	Urinary Frequency/Urgency/Pain
☐	☐	Urinary Incontinence
☐	☐	Urogenital Infection/STD
☐	☐	Urogenital Discharge/Bleeding
☐	☐	Hernia
☐	☐	Waking up at night to urinate
☐	☐	Urine Color Change/Problem
☐	☐	Irregular Cycle/Bleeding/Pain

Yes	No	
☐	☐	Joint/Bone Pain/Arthritis
☐	☐	Back Problem
☐	☐	Joint Swelling/Inflammation
☐	☐	Muscle Weakness
☐	☐	Trauma/Injuries
☐	☐	Ambulation Problem
☐	☐	Orthotics/Assistive Device
☐	☐	Decreased Mobility

Yes	No	
☐	☐	Memory Change/Problem
☐	☐	Mood Change/Problem
☐	☐	Psychiatric Medications
☐	☐	Headache/Dizziness/Fainting
☐	☐	Speech/Communication Problem
☐	☐	Weakness/Paralysis
☐	☐	Sensory Change/Numbness
☐	☐	Involuntary Movement

Signature: ____________________________ Date: ______________________________________

Office Policies

At FirstMed Family Healthcare, we are dedicated to providing excellent medical care and fostering strong patient-physician relationships. Our practice is rooted in evidence-based medicine, ensuring that the treatments and recommendations we provide are supported by the latest scientific research and clinical guidelines. These policies are designed to implement our goals efficiently, delivering the highest quality care to our patients. If you have any questions, please do not hesitate to speak with us.

1. It is the patient's responsibility to understand his/her/their plan especially in regards to referrals and pre-authorizations.
2. At each visit, please present you current insurance card and inform the staff of any changes in your personal information.
3. We will NOT refill any prescriptions or complete any forms if your last physical was over one year ago.
4. Notes to excuse from work or school will NOT be provided without an office visit.
5. Co-pays are due at the time of service.
6. There will be a charge of $1.00 per page for a copy of medical records
7. There is a $25.00 charge for missed appointments that are not cancelled at least 1 business day in advance. This will not be covered by your insurance company. If the patient accumulates four missed appointments in a calendar year, the patient may be asked to leave the practice.
8. A $25.00 fee will be charged for checks returned plus the fee from the bank.
9. Outstanding balances must be paid in full prior to the next visit.
10. The after-hours emergency phone number (201-768-1200) is for extreme emergencies only. This does not include sore throats, cold symptoms, prescription refills, referrals, or anything else that is not deemed a medical or surgical emergency. The patient's may be connected/directed to an on-call physician if deemed necessary.
11. Communication with our office staff and physicians via the patient portal is for non-emergent messages.
12. Prescription refills will be filled within 3 business days. Please call in advance when in need for a refill.
13. Referrals require a notice of five business days. Original hard copy of the referral will need to be picked up.
14. Abuse in any form will be NOT be tolerated in the practice and its premises and the patient will be asked to leave the practice immediately.

I have read thoroughly, understand, and agree to the office policies from FirstMed Family Healthcare as stated above.

Patient (or Responsible Party) Signature: ____________ Date: ____________________

Authorization For Release of Medical Records

By signing this form, I authorize ____

____

to release confidential health information about me, by releasing a copy of medical records, or a summary/narrative of my protected health information, to the facility listed below.

FirstMed Family Healthcare

244 Livngston St A, Northvale, New Jersey 07647
Phone: 201-768-1200
Fax: 201-768-4569

Patient (or Responsible Party) Name: ______________________________

Date of Birth: _________________

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Other (Please specify): _______________________________________

Patient (or Responsible Party) Signature: ___________________________

Date: _________________________

Authorization For Release of Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request medical billing information. Under the requirements of HIPPA we are not allowed to give this information without the patient's consent. If you wish to have your medical or billing information released to family members you must complete this form. Signing this form will you grant release of information to the family members or any other party listed below.

I authorize FirstMed Family Healthcare to release my medical and/or billing information to the following individuals:

Names:	Relationship:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient (or Responsible Party) Name: ______________________________

Signature: ______________________ Date: ________________