1211 Hamburg Turnpike ●Wayne NJ 07470
Tel: (973) 692-1113
1060 Clifton Avenue 1st Floor ● Clifton NJ 07013
Tel: (973) 692-1113

Patient Information Form
(PLEASE PRINT)

Date: ___/____/____

Patient Name: __________ ____________ Date Of Birth: ____/____/____ Age: ____ Sex: M F
LAST FIRST

Home Address: _________________________ City/State: ________________ Zip: __________

MAY WE LEAVE A MESSAGE?

Home Phone #: (____) ____ - ______ YES NO

Alternate Phone #: (____) ____ - ______ YES NO

E-Mail:__________________________ YES NO

Primary Language: _________________

Do you have a legal guardian or HealthCare Power Of Attorney? YES NO

If yes, Name: _____________ Relationship: _____________ Phone #: (____) _____ - _____

Emergency Contact: _____________ Relationship: _____________ Phone#: (____) _____- _____

Primary Care Doctor: _____________ Who Referred You to Us? ____________________________

Pharmacy: ________________________ Location: ________________ Phone #: (____) ____ -_______

Is There A Family Member Or Other Person You Would Like For Us To Share Your Medical Information?

____ Yes Name(s) ____

____ No

Who Is Responsible For Payment? _______________ Relationship to Patient? ______________________

Address: _______________ City/State: _____________ Zip: __________ Phone # :(____) _____ - ______

Insurance Information

Primary Insurance Company Name: ____

Address: _________________ City/State: ________________ Zip: _________ Phone #: (____) ____-____

Insured Name: _____________ Date Of Birth: ___________ Employer______________

Contract#:______________________ Group#:_______________

Secondary Insurance Company Name: ____

Address: _________________ City/State: ________________ Zip: _______ Phone #: (____) _____-_____

Insured Name: _____________ Date Of Birth: ___________ Employer______________

Contract#:______________________ Group#:_______________

Patient Name: ________________ Date of Birth: ________________

Please List All Medications You Are Currently Taking (Include Prescriptions, Over-The-Counter Meds and Herbal Supplements):

Name **Dose** **How Often Do You Take It**

____
____
____
____
____
____

Please List All Prior Surgeries:

Type of Surgery **Date** **Type of Surgery** **Date**

____________________________________ ___________________________________
____________________________________ ___________________________________
____________________________________ ___________________________________

Please List All Prior Hospitalizations (Other Than For Surgery):

Reason for Hospitalization **Date** **Reason for Hospitalization** **Date**

____________________________________ ___________________________________
____________________________________ ___________________________________
____________________________________ ___________________________________

Social History

Marital Status: □ Single □ Married □ Partnered □ Separated □ Divorced □ Widowed

Use of Alcohol: □ Never □ No Longer Use □ History of Alcohol Abuse

Use of Tobacco: □ Never □ Quit- How Long Ago? ______ □ Smoke____Packs/Day for ______ Years

Use of Recreational Drugs: □ Never □ Quit- How Long Ago? __________ Type______________

Employer: _________________________________ Occupation: ________________________

How Much Are You On Your Feet At Work? □ 10% □ 25% □ 50% □ 75% □ 100%

Do Others Depend Upon You For Their Care? □ Children- Age(s) _______ □Pet(s) - _________

Exercise: □ Never □ Rare □ Occasional □ Weekly □ Several Times a Week □ Daily

Type of Exercise: ____

Family History

Do You Have a Family History Of: □ Diabetes □ Cancer □ Heart Disease □High Blood Pressure □Stroke

□Coronary Artery Disease □ Thyroid Disease □Rheumatoid Arthritis □ Other_________

Patient Name: __________________ **Date of Birth: _______________**

Your Medical History

Allergies: □ None Known □ Medications ___________________________________

□ Anesthesia ___________________ □ Foods ______________________________

□ Tape □ Latex □ Shellfish □ Iodine □ Other ________________________________

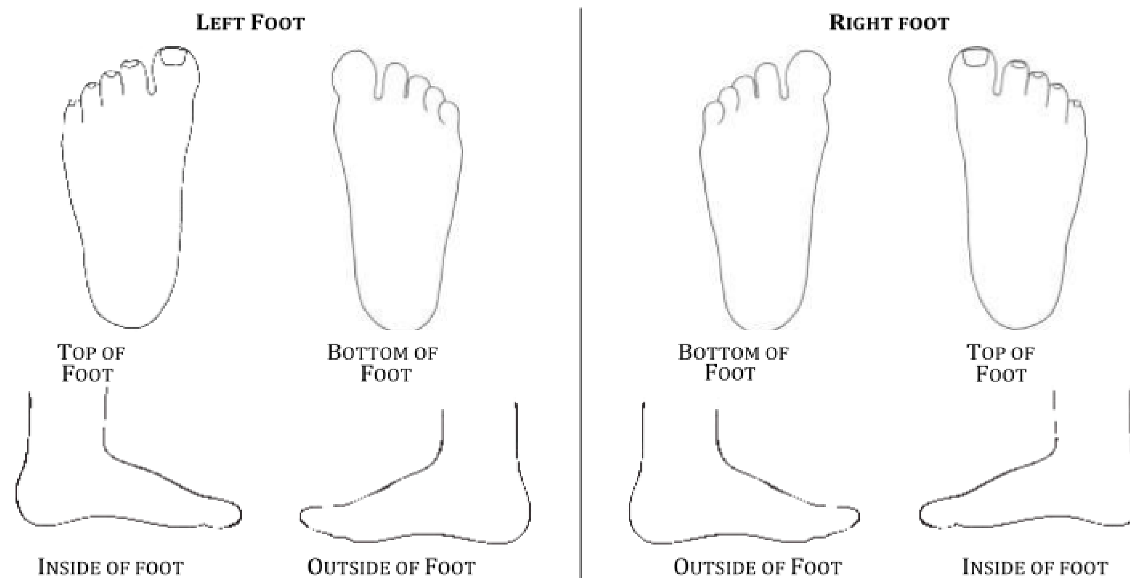
Have You Ever Had Any Of The Following?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/ FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRANE HEADACHE	Y	N	THRYOID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

Current Problem

What Specific Problem Brings You To Our Office Today? ____________________________

Where Is The Pain/Problem Located? Please Mark On The Pictures Below.



How Long Ago Did This Problem Start? _________ Days/ Weeks/Months/Years

Did Your Pain Or Problem: □ Begin All Of A Sudden? □ Gradually Develop Over Time?

How Would You Describe Your Pain? □ No Pain □ Sharp □ Dull □ Aching □ Burning □ Radiating

□ Itching □ Stabbing □ Other: ___________________________________

How Would You Rate Your Pain On A Scale From 0 To 10? (Please Circle)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Since The Time Your Pain Or Problem Began, Has It: □ Stayed The Same □ Become Worse □ Improved

What Makes Your Pain Or Problem Feel Worse? □ Walking □ Standing □ Daily Activities □ Resting

□ Dress Shoes □ High Heels □ Flat Shoes □ Any Closed Toe Shoe □ Running

□ Other:__________________________

What Makes Your Pain Or Problem Feel Better? ____

What Treatments Have You Had For This Problem?____

How Has This Problem Affected Your LifeStyle Or Ability To Work?_____________________________

Was This Problem Caused By An Injury? □ Yes (Describe) _____________________________ □ No

If Yes, Was It A Work- Related Injury? □ Yes □ No

To The Best Of My Knowledge, I Have Answered The Questions ON This Form Accurately. I Understand That Providing Incorrect Information Can Be Dangerous To My Health. I Understand That It Is My Responsibility To Inform The Doctor And Office Staff Of Any Changes In My Medical Status.

_____________________________________   _________________________________

Print Name Of Patient, Parent Or Guardian   **Signature Of Doctor**

_____________________________________   ____________________________

If Other Than Patient, Relationship To Patient   **Date**

____

Signature

____

Date

Patient Name:___________________________ Date Of Birth:______/_______/_______