THE PARK MEDICAL GROUP

WE CARE ABOUT YOUR HEALTH

24 Elm Street, Harrington Park, NJ 07640
274 County Road, Tenafly, NJ 07670
220 Livingston Street, Suite #202, Northvale, NJ 07647
1555 Center Avenue, 2nd Floor, Fort Lee, NJ 07024

PATIENT REGISTRATION FORM

Welcome! Please take a few minutes to provide us with important information on yourself that will help our staff take better care of you and that will also correct insurance billing. Please fill in all the blanks as best as you can.

****THE INSURANCE PART MUST BE FILLED OUT COMPLETELY, ESPECIALLY YOUR SIGNATURE****

Last Name_____ First Name_____ MI_____ Sex ☐ M ☐ F

Address_____ City_____ State_____ Zip Code_____

Tel_____ Cell_____

Date of Birth_____ SSN_____

Race_____ Ethnicity_____ Language(s) Spoken_____

Email_____ Driver's License Number_____ State_____
(We will need a copy of license.)

Occupation_____ Employer_____

Address_____ City_____ State_____ Zip Code_____

Work Tel_____ Ext._____

Marital Status_____ Spouse's Name_____ Tel_____

Next of Kin_____ Relationship_____ Tel_____

Emergency Contact_____ Relationship_____ Tel_____

Pharmacy_____ Tel_____

INSURANCE INFORMATION

Person responsible for your bill (guarantor): ☐ Self ☐ Spouse ☐ Other_____

PRIMARY INSURANCE

Name of Insurance Plan_____ Policy Holder_____

Policy Holder's Plan #_____ Group #_____

Date of Birth_____ SSN_____

SECONDARY INSURANCE

Name of Insurance Plan_____ Policy Holder_____

Policy Holder's Plan #_____ Group #_____

Date of Birth_____ SSN_____

SIGNATURE ON FILE & ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claims(s), to Millennium Practice Management Associates, Inc. I authorize and request payment of medical benefits directly to medical associates of Englewood Park Medical Group Division. I agree that a photocopy of this form may be used in lieu of the original. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles, co-payments, co-insurance and non-covered services.

Patient/Authorized Signature_____ **Date**_____

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PATIENT QUESTIONNAIRE

Referring Physician _____ Other Current Physician _____

MEDICAL HISTORY

Please list any past operations or procedures:

Past hospitalizations:

Current medications/supplements/vitamins:

Allergies: Medications _____

☐ Pollen ☐ Animals ☐ Shellfish ☐ Iodine ☐ Others _____

FAMILY HISTORY

Please note any diabetes, hypertension, cancers, or heart, kidney, thyroid, liver, intestinal, mental illnesses.

RELATIVE	AGE(S)	DISEASES AND/OR CAUSE OF DEATH	
Mother	_____	_____	☐ Deceased
Father	_____	_____	☐ Deceased
Brother(s)	_____	_____	
Sister(s)	_____	_____	

Children/others _____

LIFESTYLE

Have you ever smoked? ☐ Yes ☐ No If yes, what? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Other _____

When? _____ How much? _____ Have you tried to quit? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, what? ☐ Wine ☐ Liquor ☐ Cocktails ☐ Beer ☐ Other _____

How often? ☐ Weekend ☐ Daily ☐ Socially ☐ Can't tolerate it

Please Print Name _____

Patient/Authorized Signature _____ **Date** _____