CROSSROADS MEDICAL GROUP*975 CLIFTON AVE*CLIFTON*NJ*07013* 973 778 8666

REGISTRATION FORM

IT IS REQUIRED BY INSURANCE THAT WE OBTAIN ALL INFORMATION ON THIS FORM

NAME____

SOCIAL SEC. # ______________-__________-_____________

DATE OF BIRTH MONTH________DAY_____YR_________

SEX: M F

MARRIED DIVORCED WIDOW SINGLE

RACE: WHITE ASIAN AFRICAN AMER HISPANIC OTHER

LANGUAGE: ENGLISH SPANISH POLISH ARABIC OTHER

YOUR PRIMARY DOCTOR____________________________

WHO REFERRED YOU HERE_______________________

PHARMACY

YOUR **PHARMACY** : NAME___________________________

ADDRESS____

YOUR ADDRESS:_________________________________

______________________________ APT #______________

____

____

YOUR E MAIL ADDRESS

____

YOUR HOME PHONE___________________________________

YOUR CELL PHONE____________________________________

preferred method (check one) _________cell___________home

EMERGENCY CONTACT

NAME__________________________________

ADDRESS_______________________________

____

PHONE__________________________________

RELATION______________________________

YOUR PAST MEDICAL HISTORY: CIRCLE ANY THAT YOU HAVE NOW OR HAVE HAD IN THE PAST

AIDS/HIV	HEPATITIS: A B C	CANCER:
ALCOHOLISM	HEART DISEASE	WHERE________________
ARTHRITIS:	HIGH CHOLESTEROL	HYPERTENSION
OSTEO	KIDNEY DISEASE	STD
RHEUMATOID	PACEMAKER	THYROID
DIABETES	PROSTATE PROBLEM	OVERACTIVE-HYPER
TYPE 1	ENLARGED	UNDERACTIVE HYPO
TYPE 2	INFECTION	PSYCHIATRIC ISSUE
DRUG ABUSE	MRSA	DESCRIBE: _________
GOUT	SKIN INFECTION	___________________
PNEUMONIA	OTHER__________________________________	
EMPHYSEMA		

YOUR PAST SURGICAL HISTORY:

TYPE OF SURGERY AND WHAT YEAR:

ALLERGIES YOU HAVE: | REACTION YOU HAVE:

DO NOT LEAVE SPACE BLANK- IF NONE-- CHECK HERE ☐

____

____

____

ARE YOU A CURRENT SMOKER YES NO

ARE YOU A FORMER SMOKER YES NO

QUIT WHEN_____________________________________

MEDICATIONS YOU TAKE NOW:

NAME	DOSE	#TIMES A DAY

TURN PAGE OVER AND CONTINUE

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FAMILY HISTORY:	ALIVE ?	AGE AT DEATH	CAUSE of death	
FATHER				
MOTHER				
BROTHERS				birthdate
SISTERS				birthdate

DO ANY BLOOD RELATIVES HAVE:	RELATION TO YOU:
☐ CANCER WHERE_______	____________________
☐ DIABETES	____________________
☐ HEART DISEASE	____________________
☐ STROKE	____________________
☐ HIGH BLOOD PRESSURE	____________________
☐ KIDNEY DISEASE	____________________
☐ ARTHRITIS	____________________

RECENT TRAVEL-WHERE AND WHEN

OTHER INFORMATION YOU WANT TO SHARE:

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY NAME

____

POLICY NUMBER

____

NAME AND BIRTHDATE OF SUBSCRIBER IF NOT YOU:

____

DOES YOUR PLAN REQUIRE REFERRALS YES NO

SECONDARY INSURANCE

INSURANCE COMPANY NAME

____

POLICY NUMBER

____

I ASSIGN ALL PAYMENTS TO CROSSROADS MEDICAL GROUP. I AUTHORIZE THE USE OF MY HEALTH INFORMATION TO INSURANCE COMPANIES TO OBTAIN PAYMENT

I HAVE HAD OPPORTUNITY TO VIEW OR HAVE COPY OF HIPAA POLICY .

I UNDERSTAND IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE AND INFORM STAFF OF POLICY CHANGES BEFORE MY VISIT. IF INSURANCE DENIES PAYMENT DUE TO MISINFORMATION, OR A SERVICE IS DEEMED BY THEM AS BEING NON COVERED, PAYMENT FOR SERVICES IS MY RESPONSIBILITY

SIGNATURE____

DATE____

TURN PAGE OVER AND CONTINUE