PATIENT REGISTRATION FORM

First Name:	**Last Name:**	**M.I.:**
Mailing Address:		
City	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**	**Email:**
Date of Birth:	**SSN:**	**Gender:** Male Female
Marital Status: Single Married Divorced Widowed Life Partner Other (please specify):		
Race: White Black/African American Asian Native Hawaiian Other (please specify):		
Ethnicity: Hispanic or Latino Not Hispanic	**Preferred Language:** English Spanish Other (please specify):	
How did you hear about us: Family Online Newspaper Other (please specify):		

Emergency contact information (PLEASE PROVIDE TWO):		
Name:	**Phone:**	**Relationship to patient:**
Name:	**Phone:**	**Relationship to patient:**
Person responsible for the bill (ONLY IF DIFFERENT THAN PATIENT):		
Last Name:	**First Name:**	**M.I.:**
Date of Birth:	**Phone:**	**Relationship to patient:**

Primary Medical Insurance		**Secondary Medical Insurance**	
Ins. Co. Name:		**Ins. Co. Name:**	
ID#:	**Group #:**	**ID#:**	**Group #:**
Policy Holder Name:		**Policy Holder Name:**	
Policy Holder DOB:		**Policy holder DOB:**	
Policy Holder Relationship to Patient:		**Policy Holder Relationship to Patient:**	

PATIENT RECORD DISCLOSERS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI is made by alternative means, such as sending correspondence to the individual's work or cell phone instead of the individual's home.

Please rank the following modes of communication in the order in which you would like to receive calls or messages and check the options that apply regarding detailed messages:

Rank 1 2 3 4	**Home phone (as listed above)**	☐ **YES** leave messages at this number with detailed medical information.	☐ **DO NOT** leave detailed messages at this number, only leave a callback number.
Rank 1 2 3 4	**Cell phone (as listed above)**	☐ **YES** leave messages at this number with detailed medical information.	☐ **DO NOT** leave detailed messages at this number, only leave a callback number.
Rank 1 2 3 4	**Email (as listed above)**	Portal communication is verifed via your email address. Through the above email address you are given access to the encrypted patient portal which holds your medical information.	
Rank 1 2 3 4	**Text Message (To cell listed above)**	☐ **YES** leave messages at this number with detailed medical information .	☐ **DO NOT** leave detailed messages at this number, only leave a callback number.

PERMISSION TO SHARE VACCINATION INFORMATION WITH THE STATE IMMUNIZATION REGISTRY

I have reviewed information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my or my child's immunizations are due and to keep a central record of my or my child's immunization history. I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3. I understand that I can get a copy of my or my child's vaccination record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at their website: www.njiis.nj.gov or phone: 609-826-4860. Please initial next to your choice and sign.

_____ I allow sharing of my vaccination records with the state NJIIS program for the purpose of a having a complete vaccination record.

_____ I decline sharing my vaccination information with NJIIS – (staff answer Yes to decline sharing question)

AUTHORIZATION TO RECEIVE OR SEND INFORMATION

Receiving your current prescription history and progress notes from specialist as well as sending our information to them is necessary in better coordinating your care. Please initial below on either option.

_____YES, if I notify staff I have seen a specialist, outside clinician or had a test, the outside party has permission to send the most recent information to High Mountain Health.

_____ NO, Do not coordinate my care among my other service provider or pharmacies.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I hereby authorize High Mountain Health, PA to apply for benefits on my behalf for covered services rendered by my family physician, or by his/her order. I request that payment from my insurance company be made directly to High Mountain Health, PA (or to the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date: **Signature:**

If your current Primary Care office is NOT High Mountain Health and you would like your visit summaries sent to an outside office please write the information for your primary care clinician below.

Primary Provider: _____Phone:__ _____Fax:_____

To maximize continuity of care High Mountain Health recommends that you choose a primary clinician and primary location within the practice, please CIRCLE ONE

David Rasa, RPH, MD	Antoinette DeIngeniis-DePasquale, DO	Jeffrey Gold, MD, FACP	Gary Pepe, MD
Rafaella Kalishman, MD	Kaneez Odgers, APN	Andres Vega PAc	Ullanda Fyffe, MD
Magdalena Kowalski, APN	Smadar Kleinstein, PAc	Shawne Simone APN	
Helder Rebelo, PAc	Ronda White, PAc	Arkadiy Shraytman, DO	

Please circle the location to where you are handing in this form:

Wayne – Urgent Care
246 Hamburg Tpk
Ph: 973.389.1800
Fax: 973.636.2734

Wayne
468 Parish Drive
Ph: 973.305.8300
Fax: 973.305.8157

Little Falls
83 Long Hill Rd
Ph: 973.785.2440
Fax: 973.785.0141

Waldwick – Urgent Care
71 Crescent Ave
Ph: 201.445.1700
Fax: 201.445.1701

Clifton Urgent & Primary Care
721 Clifton Ave. Suite 2A
Ph: 973.777.7727
Fax: 973.779.7906

Like us on Facebook
High Mountain Medical Group

Visit our website at:
www.HighmountainHealth.com

MEDICATIONS	Preferred Pharmacy Name and Location:		
	Name of Medication	**Dose and Frequency**	**Reason for taking**

Do you smoke or have you ever smoked	Yes or No?	Number of years smoking	Smoking amount per day

MEDICAL HISTORY	Do you have any of the following diagnoses			
	Diagnosis	**Yes or No?**	**Date of Diagnosis**	**Specialist (if any)**
	Coronary Artery Disease			
	High Blood Pressure			
	Diabetes (circle one) Type I Type II			
	High Cholesterol			
	COPD			
	Asthma			
	Anxiety			
	Depression			
	Other (please specify):			
	Other (please specify):			
	Other (please specify):			

HOSPITAL VISITS	Please fill in the information for Hospital visits and Surgeries		
	Hospital	**Date**	**Reason for Visit**

ALLERGIES	Please list any Allergies	Type of Reaction

SPECIALISTS	Specialists or Other Clinicians Currently involved in your care	Reason	Date Last Seen

FAMILY HISTORY	Family Member	Status: Deceased, Alive, Unknown	Age	Medical Condition 1	Medical Condition 2	Medical Condition 3	Medical Condition 4
	Father						
	Mother						
	# of siblings:						
	# of Children:						