PATIENT INFORMATION

PT NAME____

DATE OF BIRTH__________________ AGE________ MARITAL STATUS__________________

OCCUPATION__________________________ PHONE NUMBER__________________

DO YOU HAVE AN ADVANCE DIRECTIVE? Yes or No

MEDICAL HISTORY

Check any that apply and describe

- ☐ 1. Heart trouble
- ☐ 2. Thrombosis
- ☐ 3. Hepatitis
- ☐ 4. Diabetes
- ☐ 5. Anemia
- ☐ 6. Sickle-cell trait/anemia
- ☐ 7. Thyroid Disease
- ☐ 8. Reaction to Anesthesia
- ☐ 9. Rheumatic Fever
- ☐ 10. Epilepsy/Seizure
- ☐ 11. Hypertension
- ☐ 12. Kidney Disease
- ☐ 13. Tuberculosis
- ☐ 14. Bleeding Tendencies
- ☐ 15. Asthma
- ☐ 16. Depression or Anxiety
- ☐ 17. Panic Attacks
- ☐ 18. Venereal Disease
- ☐ 19. HIV
- ☐ 20. Alcohol Use
- ☐ 21. Smoke Tobacco
- ☐ 22. "Social Drugs"
- ☐ 23. Antibiotics
- ☐ 24. Steroids
- ☐ 25. Anticoagulants
- ☐ 26. Tranquilizers
- ☐ 27. Blood pressure meds
- ☐ Other
- ☐ None of the above

Prior Surgery/Hospitalization:
None ( )

ALLERGIES or SENSITIVITIES None ( )

Medications: None ( )

First Day of Last Period:________

Of Prior Pregnancies:_____ Children:_____

C/Sections:_____ Ectopics:_____

Miscarriages:_____ Abortions:_____

Complications: None ( )

______________________________, MD Date__________

Revised: August 14, 2020

Patient Name ____________________

Address	City	State	Zip Code	County	Social Security Number

Cell Phone OK to Call Y ( ) N ( )	Home Phone OK to Call Y ( ) N ( )	Work Phone OK to Call Y ( ) N ( )	Caucasian Asian African American Hispanic Other

FAMILY MEMBER/PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name	Relationship to you	Street City State Zip Code
Cell Phone	Home Phone	Work Phone

Who Referred you to MMA____________________ Prior MMA patient? Yes No When____________

I have had nothing to eat or drink since 12:00 midnight Yes No____________________

Name of Escort____________________ Escort's Phone Number____________________

REVIEW OF SYSTEMS

Do you now or have you ever had any problems related to the following systems? Circle Yes or No

						STAFF USE ONLY
Constitutional Symptoms			**Integument**	Y	N	(Comments/Notes)
Fever	Y	N	Skin Rash	Y	N	
Chills	Y	N	Boils	Y	N	
Headache	Y	N	Persistent itch			
Eyes			**Musculoskelatal**			
Blurred Vision	Y	N	Joint pain	Y	N	
Double Vision	Y	N	Neck pain	Y	N	
Pain	Y	N	Back pain	Y	N	
Allergi/Immunologic			**Ear/Nose/Throat/Mouth**			
Hay Fever	Y	N	Ear infection	Y	N	
Drug Allergies	Y	N	Sore throat	Y	N	
Latex Allergy	Y	N	Sinus problems	Y	N	
Neurological			**Genitourinary**			
Tremors	Y	N	Urine retention	Y	N	
Dizzy Spells	Y	N	Painful urination	Y	N	
Numbness/Tingling	Y	N	Urinary Frequency	Y	N	
Endocrine			**Respiratory**			
Excessive thirst	Y	N	Wheezing	Y	N	
Too hot/cold	Y	N	Frequent cough	Y	N	
Tired	Y	N	Shortness of breath	Y	N	
Gastrointestinal			**Hematologic/Lymphatic**			
Abdominal Pain	Y	N	Swollen glands	Y	N	
Nausea/vomiting	Y	N	Blood clotting problem	Y	N	
Indigestion/heartburn	Y	N	**Psychological**			
Cardiovascular			Do you feel severely depressed?	Y	N	
Chest pain	Y	N	Have you considered suicide	Y	N	
Varicose veins	Y	N				
High Blood Pressure	Y	N				

Other Complaints

PATIENT SIGNATURE____________________ **DATE**____________

METROPOLITAN SURGICAL ASSOCIATES
40 Engle Street
Englewood, NJ 07631

☐ **ADVANCED DIRECTIVE – LIVING WILL**

On January 11, 1992, a New Jersey law took effect, which mandates that all healthcare facilities ask patients whether they have an advanced directive or living will.

Do you have an Advanced Directive or Living Will Yes___ No____
If yes, please name your healthcare representative.

_______________________________ _______________________
Name **Phone Number**

☐ **VERIFICATION OF REVIEW OF PATIENT BILL OF RIGHTS**
I certify that I have been offered/given a copy of the Patient Bill of Rights for my review and any questions that I may have had regarding them have been answered to my satisfaction.

☐ **ACKNOWLEDGEMENT OF PRIVACY NOTICE**
I acknowledge that I have been offered/given a copy of the Privacy Notice as a requirement of the federal law (HIPAA).

☐ **DISCLOSURE OF OWNERSHIP**
I have been notified that the practicing physicians at Metropolitan Surgical Associates may also hold ownership in the facility In accordance with 42 C.F.R. 416.50, I have been provided with this information prior to receiving any medical services.

_______________________________ _______________________
Patient's Signature **Date**

_______________________________ _______________________
Witness **Date**

Patient's signature indicates awareness/receipt of all of the above.

Revised: June. 2022

METROPOLITAN MEDICAL ASSOCIATES
40 Engle Street
Englewood, NJ 07631

Email & Text Message Consent Form

We may reach out to you via text and or by email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide health reminders, appointment confirmation and other information pertaining to your visit.

☐ I ______________________________, consent to and understand that this request to receive emails and/or text messages will apply to all future appointment reminders, feedback, and health information from Metropolitan Medical Associates.

The cell number that I authorize to receive text messages is:

(_______) _______ - ___________

The email that I authorize to receive email communication is:

____________________________________@__________________

☐ I ______________________________, refuse to allow Metropolitan Medical Associates to communicate with me via text messages or by email.

_______________________________________ _______________________________

Signature **Date**