One Hudson Medical Associates
Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ Home_____

Cellular_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ Home_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Student ☐ Retired ☐ Self-Employed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

235 Old River Road, Edgewater, New Jersey 07020 Phone: 201-941-4111 Fax: 201-941-4113

One Hudson Medical Associates
MEDICAL HISTORY FORM

Name: _____ Today's Date: _____
Last *First* *Middle*

Sex: _____M _____F _____Other Date of Birth: __/__/____ Occupation: _____

Marital Status: _____Married _____Single _____Divorced _____Widowed Number of Children: _____

Tobacco Use: _____Yes _____No _____Previous Use How do you consume? _____

How much per day/week/month? _____ How long for? _____ Date quit? _____

Alcohol Use: _____Yes _____No _____Previous Use

How much per day/week/month? _____ How long for? _____ Date quit? _____

Past Illness

Yes	No		Yes	No		Yes	No	
☐	☐	Alcoholism	☐	☐	Glaucoma	☐	☐	Osteoporosis
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease
☐	☐	Cancer/Tumor	☐	☐	Kidney Disease	☐	☐	Ulcer in GI Tract
☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	High Cholesterol
☐	☐	Drug abuse	☐	☐	Lung Disease	☐	☐	Other: _____
☐	☐	Depression	☐	☐	Mental Illness	☐	☐	Other: _____
☐	☐	Epilepsy/Seizures	☐	☐	Osteoarthritis	☐	☐	Other: _____

Family History: *List any illness disease of family members*

_____ _____

_____ _____

Past Surgical History: *List any procedures or surgeries in the past including dates*

_____ _____

_____ _____

Current Medications: *Include Birth Control Pills, Vitamins, and Supplements*

_____ _____

_____ _____

_____ _____

Allergies: _____ _____

Additional Information:
Last Mammogram: _____ Where: _____ Last Pap test: _____ Gyn: _____
Last Colonoscopy: _____ Normal? _____ Last Bloodwork: _____
Vaccine Dates: Tetanus: _____ Pneumonia: _____ Flu: _____ Hep B: _____

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REVIEW OF SYMPTOMS

Current Complaint: _____

Yes	No		Yes	No	
☐	☐	Appetite Change/Problem	☐	☐	Problem with Teeth/Gums/Dentures
☐	☐	Weight Change/Problem	☐	☐	Swallowing Problem
☐	☐	Change in Bowel Habits	☐	☐	Nausea/Vomiting
☐	☐	Sleep Change/Problem	☐	☐	Abdominal Pain
☐	☐	Change in Activity Tolerance	☐	☐	Heartburn/Indigestion
☐	☐	Fatigue/Weakness	☐	☐	Constipation
☐	☐	Fever/Chills	☐	☐	Diarrhea
☐	☐	Night Sweats	☐	☐	Yellow Eyes/Skin

Yes	No		Yes	No	
☐	☐	Vision Change/Problem	☐	☐	Urinary Frequency/Urgency/Pain
☐	☐	Eye Pain/Irritation/Tearing	☐	☐	Urinary Incontinence
☐	☐	Eye Redness	☐	☐	Urogenital Infection/STD
☐	☐	Eye/Ear Trauma	☐	☐	Urogenital Discharge/Bleeding
☐	☐	Hearing Change/Problem	☐	☐	Hernia
☐	☐	Ear Pain/Discharge/Infection	☐	☐	Waking up at night to urinate
☐	☐	Dizziness	☐	☐	Urine Color Change/Problem
☐	☐	Ringing in Ears	☐	☐	Irregular Cycle/Bleeding/Pain

Yes	No		Yes	No	
☐	☐	Cough/Sputum	☐	☐	Joint/Bone Pain/Arthritis
☐	☐	Respiratory Infection	☐	☐	Back Problem
☐	☐	Wheeze/Asthma	☐	☐	Joint Swelling/Inflammation
☐	☐	Chest Pain	☐	☐	Muscle Weakness
☐	☐	Out of Breath Easily/Quickly	☐	☐	Trauma/Injuries
☐	☐	Smoking/Tobacco Use	☐	☐	Ambulation Problem
☐	☐	Breast Lump/Swelling/Pain	☐	☐	Orthotics/Assistive Device
☐	☐	Breast Discharge/Bleeding	☐	☐	Decreased Mobility

Yes	No		Yes	No	
☐	☐	Chest Pain/Discomfort	☐	☐	Memory Change/Problem
☐	☐	Out of Breath Easily/Quickly	☐	☐	Mood Change/Problem
☐	☐	Palpitations	☐	☐	Psychiatric Medications
☐	☐	Swelling of Feet/Hands	☐	☐	Headache/Dizziness/Fainting
☐	☐	Leg Pain/Cramps on walking	☐	☐	Speech/Communication Problem
☐	☐	Rash/Itch/Sores/Lumps	☐	☐	Weakness/Paralysis
☐	☐	Mole Size/Number Increase	☐	☐	Sensory Change/Numbness
☐	☐	Easy Bruising/Bleeding	☐	☐	Involuntary Movement

Signature: _____ Date: _____

One Hudson Medical Associates

Office Policies

At One Hudson Medical Associates, we are dedicated to providing excellent medical care and fostering strong patient-physician relationships. Our practice is rooted in evidence-based medicine, ensuring that the treatments and recommendations we provide are supported by the latest scientific research and clinical guidelines. These policies are designed to implement our goals efficiently, delivering the highest quality care to our patients. If you have any questions, please do not hesitate to speak with us.

1. It is the patient's responsibility to understand his/her/their plan especially in regards to referrals and pre-authorizations.
2. At each visit, please present you current insurance card and inform the staff of any changes in your personal information.
3. We will NOT refill any prescriptions or complete any forms if your last physical was over one year ago.
4. Notes to excuse from work or school will NOT be provided without an office visit.
5. Co-pays are due at the time of service.
6. There will be a charge of $1.00 per page for a copy of medical records
7. There is a $25.00 charge for missed appointments that are not cancelled at least 1 business day in advance. This will not be covered by your insurance company. If the patient accumulates four missed appointments in a calendar year, the patient may be asked to leave the practice.
8. A $25.00 fee will be charged for checks returned plus the fee from the bank.
9. Outstanding balances must be paid in full prior to the next visit.
10. The after-hours emergency phone number (201-941-4111) is for extreme emergencies only. This does not include sore throats, cold symptoms, prescription refills, referrals, or anything else that is not deemed a medical or surgical emergency. The patient's may be connected/directed to an on-call physician if deemed necessary.
11. Communication with our office staff and physicians via the patient portal is for non-emergent messages.
12. Prescription refills will be filled within 3 business days. Please call in advance when in need for a refill.
13. Referrals require a notice of five business days. Original hard copy of the referral will need to be picked up.
14. Abuse in any form will be NOT be tolerated in the practice and its premises and the patient will be asked to leave the practice immediately.

I have read thoroughly, understand, and agree to the office policies from One Hudson Medical Associates as stated above.

Patient (or Responsible Party) Signature: _____ Date: _____

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One Hudson Medical Associates

Authorization For Release of Medical Records

By signing this form, I authorize _____

_____

to release confidential health information about me, by releasing a copy of medical records, or a summary/narrative of my protected health information, to the facility listed below.

One Hudson Medical Associates

235 Old River Road, Edgewater, New Jersey 07020
Phone: 201-941-4111
Fax: 201-941-4113

Patient (or Responsible Party) Name: _____

Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Other (Please specify): _____

Patient (or Responsible Party) Signature: _____

Date: _____

Authorization For Release of Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request medical billing information. Under the requirements of HIPPA we are not allowed to give this information without the patient's consent. If you wish to have your medical or billing information released to family members you must complete this form. Signing this form will you grant release of information to the family members or any other party listed below.

I authorize One Hudson Medical Associates to release my medical and/or billing information to the following individuals:

Names:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient (or Responsible Party) Name: _____

Signature: _____ Date: _____