

To streamline the registration process, please print and complete this form. It can be mailed or faxed to our office before your appointment or you can bring it with you on the day of your appointment. Our fax number is 973-267-7295.

NOTE: SECTIONS MARKED WITH ASTERISK* TO BE COMPLETED BY ASG STAFF.

*Surgeon _____ *OV _____ *Time _____

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

Patient's Nickname _____ Age _____ Date of Birth _____
(MM/DD/YYYY)

Marital Status: Single Married Divorced Widowed Other

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Social Security Number _____ Driver's License Number _____

Do you have medical insurance? Yes No

Primary Insurance _____ Policy Number _____

Policy Holders Name _____ Group Number _____
(if different than patient's)

Policy Holders Sex _____ Policy Holders Date of Birth _____
(MM/DD/YYYY)

Secondary Insurance _____ Policy Number _____

Policy Holders Name _____ Group Number _____
(if different than patient's)

Policy Holders Sex _____ Policy Holders Date of Birth _____
(MM/DD/YYYY)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will provide any necessary report or forms to assist me in making collection from the insurance company. I also authorize the insurance company to pay directly to Allied Surgical Group, P.A. the amount due in my pending claim for services rendered. I clearly understand and agree all services rendered me are charged to me and that I am personally responsible for their payment as well as any applicable fees incurred due to collection efforts that should arise. I realize that uncovered balances are also my responsibility. I hereby authorize Allied Surgical Group, P.A. to release to my insurance company any information including diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize the physicians employed by Allied Surgical Group, P.A. to examine, diagnose and treat me.

Signature _____ Date _____

Spouse/Parent's Work Phone _____

Who referred you to our practice? _____ Phone _____

Family Physician _____ Phone _____

Pharmacy Name _____ Phone _____

NOTE: Please bring all X-Rays, pathology reports and other reports

MEDICAL INFORMATION

Purpose of Visit _____

List any medications you are currently taking and the dosage.

Medication	Dose

List any allergies (drugs, food, other) _____

Medical Problems _____

Please list ALL past surgeries, what kind and when _____

Date of Last Menstrual Period _____ Age of First Menses _____

Number of Pregnancies _____ Number of Live Births _____

Age of First Live Birth _____

SOCIAL HISTORY

Smoker? Yes No If Yes, how much and how long? _____

Alcohol Use? Yes No

Drug Use? Yes No

List any family history of cancer, heart disease, diabetes, anesthesia problems: _____

Please check off any of the following that apply to your medical history:

GENERAL

- Weight Loss
- Hepatitis
- Blood Transfusions
- Use Aspirin Daily
- Use Advil®, etc.
- Take Coumadin
- Fever; Chills
- Decreased Appetite
- Hepatitis
- Bleeding Disorders

ENDOCRINE

- Diabetes
- Steroid Use Daily

LUNGS

- Shortness of Breath
- Asthma
- Chronic Pulmonary
- Lung Disease
- Pneumonia
- Lung Cancer
- Bronchitis

BREAST

- Cysts
- Skin Changes
- Pain
- Nipple Discharge
- Cancer
- Lumps or Masses
- Abnormal Mammography

HEART

- Chest Pain at Rest
- Chest Pain While Walking
- Murmur
- Irregular Heart Beat
- Angioplasty
- Artificial Heart Valve
- Heart Bypass
- Swollen Feet
- High Blood Pressure

DIGESTIVE

- Frequent Urination
- Burning on Urination
- Urine Infections
- Difficulty Urinating

- Urine Incontinence
- Kidney Stones
- Constipation
- Diarrhea
- Change in Stool Color
- Blood in Stool
- Thin or Small Stools
- Black Stools
- Groin Pain
- Colitis
- Hiatal Hernia
- Gastrointestinal
- Vomiting
- Abdominal Pain
- Back Pain
- Crohn's Disease
- Difficulty Swallowing
- Reflux
- Burning in Chest
- Nausea