REGISTRATION FORM

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 ____________ Patient's First Name ____________ Patient's 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 ______________

REGISTRATION FORM

Allied Surgical GROUP, PA

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:

Medications	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 ______________________

Allied Surgical GROUP, PA

REGISTRATION FORM

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: ____________________

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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