AIM Healthcare, LLC
1810 Englishtown Road
Old Bridge, NJ 08857

PATIENT INFORMATION

Name_____
Last First Middle Initial Marital Status

Address:_____
Street Address Apt# City State Zip

Phone:_____
Home Work Cell

Date of Birth:_____ SSN:_____ Male / Female (circle)

Employment:_____
Employer Type of Business Position

If Student:_____
School Year in School FT/PT

Primary Insurance:_____
Insurance Co. Group#/Id#

_____
Insured's Name/Relationship Insured's DOB Insured's SSN

Secondary Insurance:_____
Insurance Co. Group#/Id#

_____
Insured's Name/Relationship Insured's DOB Insured's SSN

_____
Insured's Address, Home Phone (if not same as Patient) Insured's Work Phone

Emergency Contact:_____
Name Relationship Home Phone Cell Phone

Referred By : _____

I have completed this form and certify that I am the patient or the duly authorized agent of the patient to furnish this information. I understand that although I have some insurance I am ultimately responsible for payment and that payment is due on the date the service is received. I understand that inaccurate information, omitted information or failure to register AIM Healthcare as the current practice as my primary care physician may result in a reduction or nonpayment of benefits; this will result in my responsibility for any charges incurred.

I authorize release of any medical information, history or records necessary to determine benefits, to substantiate or explain insurance claims filed and to procure payment.

I authorize insurance payments (including Medicare if applicable) to be made directly to AIM Healthcare and permit the use of signature on file or a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing.

_____ _____
Signature of Patient Date

AIM Healthcare
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Name:_____ Date of Birth:_____
Social Security Number:_____

Notice of Privacy Practices Acknowledgement

I have received Notice of Privacy Practices written in plain language. I understand the practice reserves the right to change its Notice of Privacy Practices and to make changes regarding all protected health information, resident at or controlled by this practice. I understand I may obtain the practice's current Notice of Privacy upon request.

X_____ _____
Signature Date

Authorization to Release Medical Information
I hereby authorize Associates in Internal Medicine Healthcare, LLC. And its employees and agents to use and disclose my protected information as described below.

1. I authorize the use and disclosure of they following protected health information: My entire medical record
2. I authorize the disclosure of protected health information to the following persons or Entities: Specialists/Hospitals/Insurance Company
3. I authorize the use and disclosure of protected health information for the following Purposes: Payment for services rendered
4. This authorization expires on the following date or the occurrence of the following: Until further notice/Upon my death/My notice in writing
5. I understand that this authorization is voluntary and that ACIIM may not condition treatment on my agreement to sign this authorization.
6. I understand that I may revoke this authorization at any time by notifying AIM Healthcare in writing of such revocation, but that the revocation will apply to extent that AIM Healthcare has not made us of or disclosed the protected health information in reliance on this authorization.
7. I understand that once disclosed under the authorization, my protected health information may be further disclosed by the recipient and no longer protected by the Federal Privacy Regulation.

I would prefer to be notified of my results in one of the following manners.
_____Please leave only a message stating that we have results to share with you and need you to follow-up with us.
or
_____Please leave a detailed message about my results on the following number: _____.

X_____ _____
Signature of Patient/Guardian Date signed

Date:_____

Name:_____ Date of Birth:_____

HEALTH HISTORY FORM FOR PHYSICAL/NEW PATIENT

Medical Problems	Have now	Had (Indicate when)	Medical Problems	Have now	Had (Indicate when)
Diabetes			Stomach Ulcers		
High Cholesterol			Reflux		
High Blood Pressure			Gallstones		
Asthma			Hepatitis		
Pneumonia			Other bowel problems		
Other Lung Diseases			Kidney Stones		
Heart Attack			Prostate Problems		
Heart Murmur			Other Urinary Problems		
Heart Failure			Arthritis		
Irregular Heart Beat			Bleeding Disorder		
Other Heart Disease			Transfusions		
Other Medical Problems			Sexually Transmitted Diseases		

Surgery/Operations	Physician	Date

Medications	Dosage/Strength	How Often/Frequency

Allergies to:	Type of reaction

Other physicians that currently care for you

1.	4.
2.	5.
3.	6.

Family History	Living (Age)	Deceased (Age)	Medical Problems
Father			
Mother			
Siblings			
Children			

Any blood relative with cancer of colon, breast, prostate? Colonic polyps?

Other significant family history?

Personal and Social History

Occupation:
Marital Status (name of spouse if applicable):
Careful diet?
Exercise?
Regular seatbelt use?
Practice safe sex?
Tobacco (# pkg/day for # yrs)
Alcohol (# drinks per wk)
Coffee/Tea/Caffeine Drinks (cups per day)
Drugs (what and how much)?
Have a Living Will/Advance Directive?
(Living Wills Advance Directives are written instructions communicating your wishes regarding medical care and treatment if you get to a point when you cannot make your own healthcare decisions.)

Preventive Care	Date Done	Preventive Care	Date Done
Gynecology Visit/ Pap Smear		Pneumonia Shot	
Mammogram		Flu Shot	
Bone Density Test		Colonoscopy/Sigmoidoscopy	
Tetanus/Diptheria Shot		PSA Test (men only)	
Eye Exam		Dental Exam	
Other immunizations:		Other:	

Do you have any other significant symptoms?