PILONIDAL
TREATMENT CENTER OF NJ

New Patient Information

Patient Contact Information

Name		**DOB**			
Street Address					
City		**State**		**ZIP**	
Mobile Phone		**Home Phone**			
Email		**SS #**			
Emergency Contact		**Phone**			
PMD Name		**PMD City, State**			
Pharmacy Name		**Pharmacy City, State**			

Past Medical History (check all that apply)

[ ] Hypertension [ ] Coronary artery disease / heart attack [ ] Asthma [ ] Emphysema

[ ] Diabetes [ ] Stroke [ ] Seizure [ ] Peripheral artery disease [ ] Cancer

[ ] Cirrhosis [ ] Peptic ulcer [ ] Kidney failure [ ] Other:

Medications

Name		**Dosage**		**How often?**	
Name		**Dosage**		**How often?**	
Name		**Dosage**		**How often?**	
Name		**Dosage**		**How often?**	
Name		**Dosage**		**How often?**	
Name		**Dosage**		**How often?**	

Medication Allergies

List:

3175 Route 10 Suite
500 Denville NJ 07834
www.ptcnj.com

info@ptcnj.com
Phone / 862.267.0388
Fax / 862.267.0387

General Consent, Authorization, Patient Rights and Responsibilities

I authorize Pilonidal Treatment Center of New Jersey, and any appropriately licensed clinician(s) acting on his behalf, to render hospital and medical care for my condition, which care may include routine diagnostic procedures, and such other medical treatment as may be deemed advisable by this physician. This may or may not include admission to the hospital. I acknowledge that no guarantees have been made to me about the outcome of my medical care and treatment. I understand that it may be necessary for my physician to take photographs, films, and records for medical, educational, and/or continuity of care purposes.

Protected Health Information

I have been provided a copy of the Notice of Privacy Practices for Protected Health Information. I consent to Pilonidal Treatment Center of New Jersey, and any appropriately licensed clinician(s) and administrator(s) acting on his behalf, releasing my personal Protected Health Information ("PHI"), either in writing or verbally, to carry out treatment, payment or health care operations. This includes any medical information which may be needed to process claims for medical insurance (or managed care) benefits relative to this treatment course, or which may be needed to conduct continued care planning. Health information may be shared via protected electronic mail, land mail, facsimile, or telephone.

HIPAA-approved Contact Person

I authorize the following individual to serve as a Health Insurance Portability and Accountability Act ("HIPAA")-approved contact:

Name, relationship: _____

Phone (specify cell or home): _____

I have read, and/or have been provided necessary accommodations for understanding, the above statements.

Patient signature: _____

Date: _____

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