



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?

Medication Allergies

List:



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: _____

