PLEASE PRINT AND COMPLETE ALL INFORMATION

TODAY'S DATE: _____

PATIENT INFORMATION

Name: _____Birth Date: _____ SS# _____

Address: _____

City: _____State: _____Zip: _____

Home Phone #: _____ CELL PHONE # _____

Email Address: _____

Is it okay to leave a message on your machine with results? _____

Other individuals who we may give medical information or test results to: FILL IN BLANK BELOW

_____ _____
Name and Relationship Telephone #

Sex: M____ F____ Marital Status: Married____ Single____ Widowed____ Divorced____

What language do you speak, read or write? _____

Do you have any Barriers to Care or Special Needs that we should be aware of? YES_____ NO_____

If yes, please explain: _____

Patient's Employer Name: _____Work Phone: ( )_____

Spouse's Name: _____Work Phone: ( )_____

Pharmacy's Name: _____Pharmacy Phone: ( )_____

DO YOU HAVE AN ADVANCED DIRECTIVE OR LIVING WILL? YES_____ NO_____

EMERGENCY CONTACT: **Must be a family member with different telephone number than the patient's, (Ideally a spouse or child.)**

Name and Relationship: _____Phone: _____

_____ _____
SIGNATURE OF PATIENT DATE

Pappas Family Medical Center
Health History Form (Confidential)

Name:_____ Age: _____ DOB:_____

Marital Status: Single / Married / Divorced / Widowed

WHO REFERRED YOU TO DR PAPPAS? _____

PLEASE LIST ALL MEDICATIONS CURRENTLY TAKEN AND REASONS WHY TAKING THESE MEDICATIONS:
Circle NONE if none.

LIST ALL PAST AND PRESENT MEDICAL CONDITIONS AND SURGERIES:
Circle NONE if none.

LIST ALL MEDICATION ALLERGIES:
Circle NONE if none.

FAMILY HISTORY

PLEASE LIST ANY CONDITIONS YOUR RELATIVES HAVE:
MOTHER:_____
FATHER:_____
SIBLINGS:_____

SOCIAL HISTORY

DO YOU SMOKE? _____ HOW MUCH?_____
DO YOU DRINK ALCOHOL? _____ HOW MUCH? _____
CAFFEINE CONSUMPTION? _____ HOW MUCH? _____
DO YOU USE ANY RECREATIONAL DRUGS?_____
IF SO WHICH ONES? _____

_____ _____
SIGNATURE OF PATIENT **DATE**

Pappas Family Medical, LLC
Elena C. Pappas, DO
Family Medicine
1006 Commons Way Bldg G
Toms River, NJ 08755
(P): 732-551-2003
(F): 732-551-2033

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of Pappas Family Medical. I hereby acknowledge receipt of Pappas Family Medical's Notice of Privacy Practices.

Name: _____
(Please print)

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ (Patients name). I hereby acknowledge receipt of Pappas Family Medical's Notice of Privacy Practices with respect to the patient.

Name: _____
(Please print)

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____