Advanced Medicine P.C

186 County Road 520 Suite 1 Morganville, NJ 07751
Phone: (732) 851- 4955 Fax: (732) 851 – 4957

REQUIRED PAPERWORK FOR IMMIGRATION EXAMS

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____

Address: _____City: _____ State: ____Zip Code: _____

Cell Phone: _____ Home Phone: _____Date of Birth: _____
Marital Status: M / S / D /W Race: _____ Ethnicity: _____

EMERGENCY CONTACT

Name: _____Phone #:_____Relationship:_____

IMMUNIZATION HISTORY : DO YOU HAVE ANY RECORD OF THE FOLLOWING?

MMR (if born 1957 or later) □ Yes □ No	Tetanus □ Yes □ No
Varicella (Vaccine or history of disease) □ Yes □ No	Polio (ages 2 months to 17 years) □ Yes □ No
Hib (ages 2 months to 59 months) □ Yes □ No	Hepatitis A (ages 12 to 23 months) □ Yes □ No
Hepatitis B □ Yes □ No	Meningitis (ages 11 to 18 years) □ Yes □ No
Pneumonia (ages 2 to 59 months and over 65) □ Yes □ No	Flu (during flu season) □ Yes □ No

CONSENT TO TREAT

I, the patient, authorize the clinic to examine, perform, screening procedures and/or to prescribe or provide treatment as may be medically necessary. I understand that I have the opportunity to obtain an explanation of any prescription, health condition, or diagnosis that may be found, in terms that I understand, from Advanced Medicine PC. I also understand that I have the right to an explanation of benefits, risks, and alternatives of any recommended treatment, and to be advised of all reasonable treatment options, including no treatment, and to an explanation of the risks that are involved with each alternative. I understand that if I do not comply with the recommendations of Advanced Medicine PC, such failure may result in an adverse outcome. I further agree to notify Advanced Medicine PC if I become pregnant of I believe that I may have become pregnant. As a courtesy, upon review of received test results, Advanced Medicine PC will typically call the patients with the reviewed notes from Advanced Medicine PC. If I have done testing but have not received such a call within two weeks, it is my responsibility to all and follow up with the status. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient Signature: _____ **Date:** _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

I have received a copy of this office's notice of privacy practices.

Patient Signature: _____ **Date:** _____