COMMUNITY HEALTH CENTER
Visiting Nurse Association of Central Jersey

Community Health Center, Visiting Nurse Association of Central Jersey,1301 Main Street, Asbury Park, NJ 07712

PATIENT INFORMATION

Patient Information – Preferred Language (Please Specify):_________________________ Preferred Name:________________

Last Name:	First Name:	Birthdate ((MM/DD/YYYY):

If Minor, Parent or Guardian Name and Mailing Information

Last Name:	First Name:	Previous Name (If Applicable):
Last Name:	First Name:	Previous Name (If Applicable):

Mailing Address:

City/State/Zip:

Home Phone:	Cell Phone:	Work Phone:	Social Security #:

Preferred method of contact for reminder calls and other electronically generated messages:
☐ Voicemail ☐ Text ☐ Email ☐ Opt Out

If voicemail, please select preferred number:
☐ Home ☐ Cell ☐ Work

Home Phone
☐Leave only a message with a call back number
☐OK to email to: ________________

Work Phone
☐OK to leave messages with detailed information
☐Leave only a message with a callback number

Written Medical Communication
☐OK to mail to my home address
☐OK to fax to this number: _________

Marital Status:
☐Married ☐Single ☐Divorced ☐ Widowed

Gender Preference: ☐ Male ☐ Female ☐Other
Pronoun Preferred: ☐He ☐She ☐Other

Sexual Orientation:
☐Straight (not Gay or Lesbian) ☐Lesbian or Gay ☐Bisexual ☐Other ☐Choose Not To Disclose

Student Status:
☐Full Time ☐Part Time ☐N/A

Email:

Emergency Contact Name:	Emergency Contact Phone #:	Relationship to Patient:

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individual (s) named below to escort my child for medical/dental treatments:

Name________________________________ Relationship_________________________
Name________________________________ Relationship_________________________
Name________________________________ Relationship_________________________

This consent shall be considered in effect until rescinded or revoked.

Person other than you, authorized to receive information:
Please check the type(s) of information each person is authorized to receive.

☐Medical Information ☐Financial Information			☐Medical Information ☐Financial Information		
Name	Relationship	Phone Number	Name	Relationship	Phone Number

Print Patient Name:____________________ Signature:__________________________ Date:____________________

ADDITIONAL NFORMATION

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

FAMILY SIZE: _________ ANNUAL INCOME: _________ ☐ REFUSE TO DISCLOSE

Race (please select):
☐White/Caucasian ☐Black/African American ☐More than one race Asian
☐Other Pacific Islander Native Hawaiian ☐American Indian / Alaskan Native

Ethnicity (please select):
☐Hispanic ☐Non-Hispanic

Migrant Worker Status (please select):
☐Migrant Worker ☐Seasonal ☐Non-Migrant Worker

Veteran Status (please select):
☐Veteran ☐Non-Veteran

Homelessness Status:
☐ Non-Homeless ☐Homeless Shelter ☐Transitional ☐Doubling-Up ☐Street ☐Other

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GUARANTOR / INSURANCE INFORMATION

Guarantor Information

☐Self ☐Parent or Guardian (if under 18) ☐Spouse ☐Partner ☐Other

Name: ________________________ Date of Birth: __________________ Social Security Number: ____________________

Address: _______________________________ City, State: ______________________________ Zip Code: ____________

Phone: _________________________________ ☐ Home ☐ Cell ☐ Work

Phone: _________________________________ ☐ Home ☐ Cell ☐ Work

Medical Insurance

Primary Medical Insurance:	Secondary Medical Insurance:
Insurance Company Name:	Insurance Company Name:
Policy Holder Name:	Policy Holder Name:
ID Number:	ID Number:
Group Number:	Group Number:
Is Today's Visit Accident or Work Related? ☐Yes ☐No	Claim Number:

Workman's Comp. / Auto Insurance Name, Address and Phone Number:

Policy Claim Number: ____________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I understand and agree that Visiting Nurse Association of Central Jersey (VNACJ) and its employees and agents may use and disclose protected health information about me for payment, treatment, and/or health care options. I request that payment of authorized insurance benefits be made either to me or on my behalf to VNACJ for any services furnished to me by VNACJ and its employees and agents. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

PHOTOGRAPH AUTHORIZATION

I hereby authorize Visiting Nurse Association of Central Jersey (VNACJ) and their colleagues to take photographs of me while undergoing medical testing and surgery. These photographs may be used for teaching or promotional purposes.

HIPPA

I have received/reviewed a copy of Visiting Nurse Association of Central Jersey (VNACJ) Notice of Privacy Practices.

Signature of Responsible Party:___________________________________

Date: ____

Printed Name of Responsible Party:Date: ___________________________