

1803 NJ-35 • Oakhurst, NJ 07755  
P: 732-531-0100 • F: 732-531-0144  
www.familyfirst-urgentcare.com  
E-mail: info@familyfirst-urgentcare.com



1851B Hooper Ave. • Toms River, NJ 08753  
P: 732-255-2001 • F: 732-255-2020  
www.familyfirst-urgentcare.com  
E-mail: infotr@familyfirst-urgentcare.com

<b>Patient Name:</b>		<b>Date of Birth:</b>	
<b>Mailing Address:</b>		<b>APT#:</b>	
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	
<b>Can we contact you through our patient portal?</b> YES      or      NO		<b>Email:</b>	
<b>Home Phone #:</b>	<b>Cell Phone #:</b>	<b>Work Phone #:</b>	
<b>Sex:</b> (CIRCLE ANSWER) Male    Female    Transgender	<b>Marital Status:</b> (CIRCLE ANSWER) Single    Married    Partnered    Divorced    Widowed		
<b>Physician Name:</b>		<b>Phone #:</b>	
<b>Physician Address:</b>			
<b>Pharmacy Name and Address:</b>			
<b>Emergency Contact:</b>		<b>Phone #:</b>	<b>Relationship to Patient:</b>
<b>PRIMARY INSURANCE INFORMATION</b>			
<b>Insurance:</b>		<b>ID #:</b>	
<b>Policy Holder Name:</b>		<b>DOB:</b>	<b>Relationship to Patient:</b>
<b>Policy Holder Address:</b>			

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## FINANCIAL POLICY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

### Individual's Financial Responsibility

- I understand that I am financially responsible for any co-pay, co-insurance, deductible, or the cost of any non-covered service.  
*\*Please be aware that some services provided may not be covered and/or considered reasonable and necessary under the Medicare program and/or other medical insurances.*
- I understand that payment in **FULL** is due at the time services are rendered.
- I understand that if my insurance requires a referral, I must obtain it prior to my visit.
- I understand that I will be responsible for any charges should my insurance deem a service "not payable".
- Should payment be sent directly to me, I understand it is my responsibility to forward payment directly to MVP Medical Associates, d.b.a. Family First Urgent Care
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

**COMPLETION OF FORMS:** \$25.00 to complete physical/pre-employment/sports physicals/insurance request forms if not provided at time of service. *Please allow **48 hours** for completion.*

**COLLECTIONS:** Any fees or surcharges imposed by a collection agency will be your responsibility, along with the full outstanding balance from your visit.

**MEDICAL RECORDS:** Request for medical records must be made in writing. Please allow **72 hours** for completion.

**I authorize the release of any information necessary to process the health claims for my care.**

**I authorize the insurance company to forward payment directly to the physicians.**

\_\_\_\_\_  
**SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

\_\_\_\_\_  
**DATE**



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

CURRENT MEDICATIONS (prescription and over the counter)	DOSAGE	FREQUENCY

PAST MEDICAL HISTORY (Please <b>CIRCLE</b> all that apply to you)			
Alcohol/Drug Abuse	COPD/Emphysema	Heart Murmur	Liver Disease
Allergies	Coronary Artery Disease	Hepatitis	Pacemaker
Anemia	Congestive Heart Failure	High Blood Pressure	Psychiatric Problems
Atrial Fibrillation	Depression	High Cholesterol	Seizure
Asthma	Diabetes	Hypo/hyperthyroidism	Stroke
Cancer	Heart Attack	Kidney Disease	Vascular Disease

- Please list any additional medical diagnoses that you have that are not mentioned above:  
\_\_\_\_\_
- Please list any significant Family Medical history:  
\_\_\_\_\_
- Are you fully vaccinated against COVID-19? Please circle:    Yes    or    No
- If yes, please list vaccine type and date of last vaccine recieved.  
\_\_\_\_\_

ALLERGIES	REACTION (hives, anaphylaxis, etc.)

PAST SURGERIES	DATE	SURGEON

- Smoking History (Please circle): Nonsmoker/Former/Current
- Do you drink alcohol (Please circle)? Yes/No



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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