

**PRIMARY CARE ASSOCIATES OF NEW JERSEY, LLC
PATIENT REGISTRATION & HEALTH QUESTIONNAIRE**



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|--------------------------------------|-------------|----------------|-----------------|
| PATIENT Name: Last: | | First: | Middle: |
| Street Address: | | | |
| Zip: | City: | State: | |
| Home Phone: | Work Phone: | Cell Phone: | |
| Sex: | SS#: | Date of Birth: | Marital Status: |
| Employer/School Name & Address: | | | |
| Spouse's Name: | | Date of Birth: | |
| Spouse's Employer: | | Phone No: | |
| Father's Name (if patient is minor): | | Date of Birth: | |
| Father's Address: | | Phone No: | |
| Mother's Name (if patient is minor): | | Date of Birth: | |
| Mother's Address: | | Phone No: | |
| Emergency Contact: | | Referred By: | |

INSURANCE & BILLING INFORMATION

| | | |
|---|------|----------------------|
| Name of Person Responsible for Bill: | | Relationship: |
| Address: | | Phone: |
| Primary Insurance Name: | | |
| Name of Insured: | DOB: | Relation to Patient: |
| Secondary Insurance Name: | | |
| Name of Insured: | DOB: | Relation to Patient: |
| Laboratory to be used as required by your insurance - if known: | | |

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct Payment of surgical / medical benefits to Primary Care Associates of New Jersey, LLC for services rendered by their practitioners or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I also give my permission to PCANJ, LLC to act as my agent with regard to any of my insurance issues.

A photocopy / scanned copy of these assignments shall be as valid as the original.

| | |
|--|--------------------------|
| Patient Name (please print): | |
| Signature: | Date: |
| If the person signing is not the Patient, please print your name and your relationship to the Patient. | |
| Name (printed): | Relationship to Patient: |

ACKNOWLEDGMENT OF PRIVACY PRACTICES NOTIFICATION

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Primary Care Associates of New Jersey, LLC.

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|--|--------------------------|
| Signature: | Date: |
| If the person signing is not the Patient, please print your name and your relationship to the Patient. | |
| Name (printed): | Relationship to Patient: |

For office use: If unable to obtain acknowledgement state reasons why efforts made to obtain acknowledgement.

PERMISSION TO DISCLOSE MEDICAL INFORMATION TO ANOTHER

With regard to my/my child's medical condition and medical records, I give permission to the Staff of Primary Care Associates of NJ, LLC to speak to the person(s) listed below. (You may indicate "no one".) Permission remains in effect until such time that it is specifically revoked in writing. You may, at any time, revoke any and all designees. Other doctors/medical entities need not be listed.

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|-----------------------------|---------------|
| Name: | Relationship: |
| Name: | Relationship: |
| Name: | Relationship: |
| Patient/Guardian Signature: | Date: |

PRIMARY CARE ASSOCIATES OF NEW JERSEY, LLC COMPLETE PHYSICAL HEALTH QUESTIONNAIRE



Name: _____ Sex: _____ Date of Birth: _____ Marital Status: _____

Occupation / Employer: _____

FAMILY HISTORY

Next to each family member listed, please indicate the relative's **age**, **(A)**live or **(D)**eceased. If still living, note Health Status as **(G)**ood, **(F)**air or **(P)**oor. Use the space provided to list any other significant medical conditions/ illnesses in family.

Mother: _____ Father: _____

Sister(s): _____ Brother(s): _____

HEALTH HISTORY:

BELOW PLEASE INDICATE ALL BLOOD RELATIVES OF **THE PATIENT** WHO HAVE HAD ANY OF THE FOLLOWING PROBLEMS. PLEASE USE THE FOLLOWING ABBREVIATIONS: (P) PATIENT, (F) FATHER, (M) MOTHER, (B) BROTHER, (S) SISTER, (MM) MOTHER'S MOTHER, (MF) MOTHER'S FATHER, (FM) FATHER'S MOTHER, (FF) FATHER'S FATHER, (A) AUNT, (U) UNCLE, (C) COUSIN

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|--------------------|-----------------|---------------------|----------------|---------------------|
| Alcoholism | Cancer | Glaucoma | Measles | Strep Throat |
| Anemia | Chicken Pox | Hayfever | Mental Illness | Stroke |
| Arthritis | Cystic Fibrosis | Heart Disease | Migraine | Sudden Infant Death |
| Asthma | Diabetes | Hepatitis | Mumps | Thyroid |
| Birth Defects | Early Deafness | High Blood Pressure | Osteoporosis | Urinary Infections |
| Bleeds easily | Eczema / Hives | High Cholesterol | Scarlet Fever | Whooping Cough |
| Blood Transfusions | Epilepsy | Joint Problems | Seizures | |

List any other medical history, with details & dates, and any other changes in medical or personal information we should know:

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|-------------------------------------|---|---------------------------|---|---|
| Alcohol _____ oz per wk Preference: | Smoking: _____ cigarettes/day for _____ # years Year quit _____ | Street Drugs: Y / N Type? | Exercise? Y / N Type: Times/week: Min/time: | MALES: Prostate Trouble Y / N Premature Ejaculation? Y / N Difficulty attaining / sustaining erection? Y / N |
|-------------------------------------|---|---------------------------|---|---|

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|--|--------------------------------|--|
| FEMALES: Menstrual Flow: Regular? Y / N | Menstrual Pain / Cramps? Y / N | Pain / Bleeding during or after sex? Y / N |
| First day of last period (date): | Number of days of flow: | Length of Cycle: |
| Flushing or Menopause? Y / N | Birth control method? | Name of birth control pills? |
| Number of Pregnancies? | Number of Abortions? | Number of Miscarriages? |
| | | Number of Live Births? |
| Date of last pap test? | Normal / Abnormal | Date of last mammogram? Normal / Abnormal |

| HOSPITAL ADMISSIONS <i>not including pregnancies</i> | YEAR | ILLNESS OR OPERATION | YEAR | ILLNESS OR OPERATION |
|---|------|----------------------|------|----------------------|
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| LIST ALL PRESCRIPTION MEDICATIONS YOU ARE NOW TAKING | ALL OVER THE COUNTER MEDICATIONS & SUPPLEMENTS |
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| ALLERGIES / REACTION / WHEN | VACCINES YEAR OF LAST | TEST / EXAM | YEAR | TEST / EXAM | YEAR |
|-----------------------------|-----------------------|----------------|------|-------------|------|
| | Tetanus/TD | Rectal / Stool | | TB Test | |
| | Influenza (flu) | Cholesterol | | EKG | |
| | Pneumonia | Eye Exam | | Colonoscopy | |
| | Hepatitis | Dental Visit | | | |

Finance Charge: A finance charge can be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and one half percent (1½%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen percent (18%). The finance charge on your account is computed by applying the periodic rate 1½% to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is \$.50.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Failure to pay at time of service will result in a billing penalty charge of \$25.00 per missed co-payment.

Returned checks: There is a fee (currently \$25.00) for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we need to send past due letters and certified letters, your account will be assessed a charge of \$25.00 for each letter sent, plus the cost of postage. In case of suit, you agree the venue shall be in Morris County, New Jersey.

Waiver of confidentiality: Authorization is given to release or receive any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently \$1.00 per page, \$10.00 minimum charge, not to exceed \$100.00 per chart copied) if you want to have copies of your records sent to yourself, another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this, or another Financial Policy, is signed by different person on the account, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____ Initials