

# Surgical Associates of Central New Jersey

## PATIENT INFORMATION

**Name:** \_\_\_\_\_ **Sex:** Male Female  
LAST FIRST MI

**Address:** \_\_\_\_\_ **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
STREET / P.O. BOX

\_\_\_\_\_ **SS#** \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
CITY STATE ZIP CODE

**Home #** (\_\_\_\_) \_\_\_\_\_ O.K. to leave a detailed message? Y N

**Work #** (\_\_\_\_) \_\_\_\_\_ O.K. to leave a detailed message? Y N

**Cell / Pager #** (\_\_\_\_) \_\_\_\_\_ O.K. to leave a detailed message? Y N

**Referred By:** \_\_\_\_\_ **Referrer's Phone#** (\_\_\_\_) \_\_\_\_\_

**Family Doctor:** \_\_\_\_\_ **Family Doctor's Phone#** (\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

**Primary Insurance:** \_\_\_\_\_ **Policy#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_ **Insured SS#:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Insured's Employer:** \_\_\_\_\_

**Insured's Relationship To Patient:** Self Spouse Parent Other **Insured's Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Policy#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_ **Insured SS#:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Insured's Employer:** \_\_\_\_\_

**Insured's Relationship To Patient:** Self Spouse Parent Other **Insured's Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

## OTHER INFORMATION

List any people that you give our staff / doctors permission to speak with regarding your medical condition (i.e. spouse, children, siblings etc.)

Name	Telephone #	Cell #	Relationship to Patient
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

## RELEASE OF INFORMATION / ASSIGNMENT OF INSURANCE BENEFITS

I consent to the use or disclosure of my protected health information (PHI) by Surgical Associates of Central NJ for the purpose of diagnosing or providing medical treatment to me, obtaining payment for my health care bills or to conduct other health care operations. I also give permission for Surgical Associates of Central NJ to receive any of my PHI from another physician or healthcare facility for the same purpose. I authorize payment of medical benefits directly to Surgical Associates of Central NJ.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REVIEW OF SYSTEMS, PAST, FAMILY AND SOCIAL HISTORY QUESTIONNAIRE

PLEASE ANSWER ALL THE QUESTIONS BELOW

NAME \_\_\_\_\_ DATE \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_ REASON FOR COMING HERE \_\_\_\_\_

LIST ANY ALLERGIES TO DRUGS, IODINE, SHELLFISH OR LATEX \_\_\_\_\_

DO YOU REGULARLY TAKE ANY MEDICATIONS (INCLUDING ASPIRIN, ADVIL, VITAMINS, ETC.) Y N

PLEASE LIST THEM ON THE MEDICATION LIST SHEET

PAST SURGERIES: LIST SURGERY AND YEAR \_\_\_\_\_

LIST ANY MEDICAL PROBLEMS THAT YOU SEE A DOCTOR REGULARLY FOR: \_\_\_\_\_

HOSPITALIZATIONS: LIST REASON AND YEAR \_\_\_\_\_

DO YOU HAVE NOW OR HAVE YOU EVER BEEN TREATED FOR:

- Diabetes, Heart Attack, Heart Problems, Stroke, Mini Stroke, High Blood Pressure, Hepatitis, Lung Problems, Kidney Problems

SOCIAL HISTORY: MARITAL STATUS \_\_\_\_\_ OCCUPATION \_\_\_\_\_

DO YOU SMOKE NOW? \_\_\_\_\_ IN THE PAST? \_\_\_\_\_ HOW MUCH AND HOW LONG \_\_\_\_\_

HOW MUCH ALCOHOL (INCLUDING BEER AND WINE) DO YOU DRINK PER WEEK? \_\_\_\_\_

LIST ANY MEDICAL CONDITIONS OR CANCERS THAT FAMILY MEMBERS (PARENTS, GRANDPARENTS, SIBLINGS, CHILDREN) HAVE BEEN TREATED FOR \_\_\_\_\_

PLEASE MAKE A CHECK MARK NEXT TO EACH OF THE CONDITIONS OR SYMPTOMS THAT YOU CURRENTLY HAVE OR HAVE BEEN TREATED FOR IN THE PAST.

CONSTITUTIONAL

- Weight Loss, Recurrent Fevers, Chills, Night Sweats, Weakness

EYES

- Blurred Vision, Double Vision, "SHADE" BLOCKED VISION

CV

- Chest Pain, Angina, Palpitations, Pain in Legs when Walking, Pain in Feet while Sleeping

ALLERGY / IMMUN

- AIDS, Recurrent Infections, Chronic Steroid Use

RESP.

- Chronic Cough, Asthma, Pneumonia

GI

- Chronic Heartburn, Recurrent Nausea-Vomiting, Blood in Stool, Black Stools, Jaundice

NEUROLOGIC

- Fainting, Paralysis, Seizures

GU

- Pain with Urination, Blood in Urine, Frequent Urination at Night

PSYCH.

- Anxiety, Depression

MUSC / SKEL

- Chronic Joint Pain, Varicose Veins, Prolonged Leg Swelling

ENDOCRINE

- Hot Flashes, Hair Loss, Thyroid, Always Thirsty

SKIN BREAST

- Itching, Chronic Rash, Breast Lump, Masses in or under Skin

HEMA / LYMPH

- Painful Lymph Nodes, Bleeding Problems, Anemia, Swollen Lymph Nodes

LIST ALL OF YOUR MEDICATIONS ON MEDICATION LIST (PAGE 2)



## Assignment of Medical Insurance Benefits

Thank you for choosing Surgical Associates of Central New Jersey. We will work with you to help you with your insurance claims, but would like you to understand our office policy regarding insurance assignment.

Payment is expected at the time of service unless we accept assignment with your insurance company or previous payment arrangements have been made. For our office to accept insurance assignment, we ask that you read and sign the following.

You acknowledge that it is your responsibility to:

1. Provide complete up-to-date information on medical insurance coverage for the patient.
2. Be able to present a valid insurance card when requested.
3. Pay applicable co-payment at the time of service.
4. Present a valid referral or authorization number for all services (if required by your insurance company).
5. Inform us if the patient's need for medical services is due to a motor vehicle, worker's compensation or other accident.
6. Make payment within 30 days any balance on your account for any amount due such as deductibles, co-insurance, co-payments or non-covered services.
7. Contact your insurance company to verify what referrals are required for surgical procedures prior to your surgery.

**You are ultimately responsible to pay the medical bill if your insurance company does not honor the assignment of benefits in whole or in part.**

Your signature below indicates:

1. You understand and accept our policy of assignment of insurance benefits.
2. You attest to the accuracy and completeness of the medical insurance coverage information.
3. You authorize this office to release medical information necessary to process your claims and appeals.
4. You authorize payment of medical benefits to Surgical Associates of Central New Jersey.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**The Breast Cancer Institute at Steeplechase Cancer Center  
Breast History and Risk Assessment Form**

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Race:** \_\_\_\_\_

**Personal Breast History**

**Location**

Have you ever had a previous mammogram?	Y	N			What years? _____ Results _____
Have you ever had a previous ultrasound?	Y	N			What years? _____ Results _____
Have you ever had previous MRI?	Y	N			What years? _____ Results _____
Have you ever had a previous breast biopsy?	Y	N	Right	Left	When? _____ Results _____
Have you ever had a breast cyst aspirated?	Y	N	Right	Left	When? _____
Do you have breast pain?	Y	N	Right	Left	
Do you have a lump that you can feel?	Y	N	Right	Left	
Do you have a lump that your doctor can feel?	Y	N	Right	Left	
Do you have regular periods?	Y	N			Date of Last Menstrual Period? ____/____/____
Do you have a nipple discharge?	Y	N			
Are you BRCA positive?	Y	N			

**Family History:**

Have **YOU** or any of your **family** members ever been diagnosed with any of the following?

Breast Cancer	Y	N	What relation? _____	Mother or father's side? _____	Age at diagnosis _____	Present Age _____
Colon Cancer	Y	N	What relation? _____	Mother or father's side? _____	Age at diagnosis _____	Present Age _____
Ovarian Cancer	Y	N	What relation? _____	Mother or father's side? _____	Age at diagnosis _____	Present Age _____
Uterine Cancer	Y	N	What relation? _____	Mother or father's side? _____	Age at diagnosis _____	Present Age _____

**Radiation History:**

Have you ever received radiation exposure to your chest wall? (e.g., Hodgkin's therapy, repeated fluorosopies)      Y      N

**Alcohol History:** Do you drink alcohol?      Y      N      How many drinks per week? \_\_\_\_\_

**Tobacco History:** Have you ever smoked?      Y      N      Age started: \_\_\_\_\_      Age when quit: \_\_\_\_\_      Packs per day: \_\_\_\_\_

**Sun Exposure History:** Frequent sun exposure (past or present)?      Y      N      Frequent sunburns?      Y      N

**Reproductive History:**

Age at first period \_\_\_\_\_ Age at menopause \_\_\_\_\_

Have you ever been pregnant? Y N If yes, how many times? \_\_\_\_\_ If yes, have you ever had preclampsia? Y N

(If not, skip down to the *Hormonal / Drug History* Section)

Please fill in the length of each pregnancy by the **# of weeks:** (a full-term pregnancy is 40 weeks)

Pregnancy	1st	2nd	3rd	4th	5th	6th	7th
How old were you at the end of each pregnancy							
What was the outcome of each pregnancy?							
Live Birth: How many weeks?							
Multiple Birth: How many weeks?							
Still Birth: How many weeks?							
Miscarriage: How many weeks?							
D&C after fetus (baby) died: How many weeks?							
Abortion: How many weeks?							
Ectopic Pregnancy: How many weeks?							
Did you breastfeed? How many weeks?							

**Hormonal Drug History:**

Have you ever used a hormone replacement? (e.g., estrogen, progesterone, Provera, Premarin) Y N

Name: \_\_\_\_\_ How long used? \_\_\_\_\_ Age when started: \_\_\_\_\_

Have you ever used fertility drugs? (e.g., Clomid, Pergonal) Y N Age when started: \_\_\_\_\_

Name: \_\_\_\_\_ How long used? \_\_\_\_\_

**Contraceptive History:**

Have you ever used any of the following?

Birth Control Pills? Y N

Name: \_\_\_\_\_ Age when started: \_\_\_\_\_ Age when stopped: \_\_\_\_\_ Reason for discontinuing? \_\_\_\_\_

Name: \_\_\_\_\_ Age when started: \_\_\_\_\_ Age when stopped: \_\_\_\_\_ Reason for discontinuing? \_\_\_\_\_

Name: \_\_\_\_\_ Age when started: \_\_\_\_\_ Age when stopped: \_\_\_\_\_ Reason for discontinuing? \_\_\_\_\_

Contraceptive injectable and/or device? (e.g., Nueva Ring, Norplant, Depoprovera, IUD, Patch) Y N Age when started: \_\_\_\_\_

How long used? \_\_\_\_\_