

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