Registration Form

Please complete this form print it out and bring to your appointment

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

DATE OF BIRTH: ____/____/____ HOME PHONE: _____ CELL PHONE _____

AGE: _____ MARITAL STATUS: M S W D SOCIAL SECURITY#_____-_____-_____

EMPLOYER: _____ FT / PT

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

WORK PHONE: _____ E-MAIL: _____

OCCUPATION: _____ DRIVERS LIC. #:_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

SPOUSE/EMERGENCY CONTACT: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY COVERAGE (IF MOTOR VEHICLE ACCIDENT – LIST MOTOR VEHICLE INSURANCE FIRST)

NAME OF INSURANCE CO.:_____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

CONTACT PERSON (ADJUSTER): _____ PHONE: _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

POLICY ID#: _____ GROUP #: _____

SECONDARY COVERAGE (PLEASE WRITE "NONE" IF THERE IS NO SECONDARY INSURANCE)

NAME OF INSURANCE CO.:_____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

CONTACT PERSON (ADJUSTER): _____ PHONE: _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

POLICY ID#: _____ GROUP #: _____

CHECK IF APPLICABLE:

MOTOR VEHICLE ACCIDENT _____ **WORK INJURY** _____ **DATE OF ACCIDENT** _____

CONFIDENTIAL HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name: _____ Date: _____

CURRENT COMPLAINTS:

□ Headaches □ Neck Pain □ Arm Pain □ Arm/Hand Numbness □ Mid Back Pain □ Chest Pain □ Low Back Pain
□ Buttock Pain □ Hip Pain □ Leg Pain □ Leg/Foot Numbness □ Other _____

ONSET (How did your pain start?): □ Unknown □ Woke-up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain: _____

_____

_____

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Caner – Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□ Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Problem
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass Out
□ Pneumonia	□ Reflux	□ Rheumatic Fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other: _____			

FAMILY MEDICAL HISTORY:

Mother:	Age: _____	( ) Living	( ) Deceased
Father:	Age: _____	( ) Living	( ) Deceased
Siblings:	Age: _____	( ) Living	( ) Deceased

Please check each box with if any family member (mother, father or siblings) has had any of the following:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Caner – Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□ Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Problem
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass Out
□ Pneumonia	□ Reflux	□ Rheumatic Fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other: _____			

CURRENT MEDICATIONS: Please list **all** current medications below or provide us with a list of medications:

Name of Medicine	Strength	Dosage

List of known ALLERGIES: _____

_____

( ) Tobacco ( ) Type: _____ ( ) Alcohol Type: _____
( ) Year begun: _____ How often: _____
( ) Still smoking: _____ How much: _____
( ) Year quit: _____ How many years: _____
( ) Packs per day: _____
( ) Exercise ( ) None ( ) Light ( ) Moderate ( ) Heavy
Other: _____

_____

_____

REVIEW OF SYSTEMS: Do you have (had) the following:

Check the appropriate box(s)

GENERAL: □ Weight gain □ Weight loss □ Fever □ Hair loss
□ Weakness □ Other: _____

EYES: □ Eye strain □ Wear glasses or contact lenses □ Sensitivity to light

EAR, NOSE THROAT □ Ringing in ears □ Hearing loss □ Discharge or pain □ Dizziness
□ Runny nose □ Difficulty Breathing through nose □ Sinusitis
□ Painful teeth, gums or palate □ Growths in the mouth
□ Pain or difficulty swallowing □ Hoarseness

CARDIOVASCULAR: □ Palpitations □ Chest pain □ Fainting □ Dizziness
□ Varicose veins □ Difficulty Climbing Stairs □ Pain in the legs
□ Cold Feet/Hands □ Shortness of breath

RESPIRATORY: □ Shortness of breath while walking □ Cough with or without phlegm
□ Asthma/Wheezing □ Spit up blood
□ Other: _____

GASTROINTESTINAL: □ Abdominal pain □ Nausea □ Vomiting □ Diarrhea
□ Hemorrhoids □ Change in shape or color of stool

GENITOURINARY: □ Discharge □ Pain □ Frequent urination □ Pain with urination

MUSCULOSKELETAL: □ Weakness □ Back Pain □ Neck Pain □ Leg Pain
□ Arm Pain □ Shoulder Pain □ Numbness □ Headaches
□ Other: _____

SKIN: □ Jaundice □ Dry Skin □ Pigment Change □ Growths
□ Moles that have changed color, shape or bleed

NEUROLOGIC: □ Tremors □ Weakness □ Numbness □ Memory Loss
□ Confusion □ Other: _____

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures, I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to **Hoboken Integrated Healthcare** to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose the protected health information. You have a legal right to review our Notice of Privacy Practices before you sign the consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at **201 – 798 – 2922**. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request, however, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSET TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration for its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, not is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

X _____
Print Patient's Name

X _____
Patient's Signature

X _____
Parent / Guardian (If under the age of 18)

91 Washington Street
Hoboken, NJ 07030
P: 201-798-2922 / F: 201-798-0307

ATTENTION PATIENTS

As a courtesy to our patients, we will submit claims to your health insurance for all services rendered in our office. Please be aware that your insurance company **may** send payments made directly payable to you instead of this office. We ask that you bring in the check(s) and the explanation of benefits statement to this office immediately upon receipt.

Please note that these payments **must** be presented to the office, otherwise **you** will be held responsible for the payment to your account.

If you have any questions or concerns, please do not hesitate to speak with me.

Please sign and return to the front desk.

_____

Print Patient Name

_____

Patient Signature

ASSIGNMENT OF BENEFITS FORM

Hoboken Integrated Healthcare
91 Washington Street
Hoboken, NJ 07030
P: 201-798-2922

Date: _____

Patient Name:
Employer:
Claim Group:
SS# / ID#:

I hereby instruct and direct _____ Insurance Company to pay by check made payable to and mailed to:

Hoboken Integrated Healthcare
91 Washington Street
Hoboken, NJ 07030

or the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my debtedness to above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner or my health care provider for any reason on my behalf.

X _____ Date: _____
Signature of Policyholder

X _____ Date: _____
Signature of Claimant if other than Policyholder

X _____ Date: _____
Witness