JFK Medical Associates

(Please Print)

Date: _____

Patient Information:

Name: _____ SS # _____
Last name First Middle Initial

Address: _____ Cell Phone: (____)_____

City: _____ State: _____ Zip: _____ Home Phone: (____)_____

Sex: □ M □ F Age:_____ Birthdate: _____ □Married □ Widowed □ Single □Minor

E-mail Address: _____ □Separated □ Divorced □ Partnered for___years

Patient Employer/School: _____ Occupation:_____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone: (_____)_____

Primary Insurance:

Person Responsible for Account: _____
Last name First Middle Initial

Relation to Patient: _____ Birthdate: _____ Soc. Sec #:_____

Address (If different from patient's): _____ Phone: (___)_____

City: _____ State: _____ Zip: _____

Person Responsible employed by: _____ Occupation:_____

Business Address: _____ Business Phone: (____)_____

Insurance Company: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Names of other Dependents covered under this plan: _____

Additional Insurance:

Is patient covered by Additional Insurance? □Yes □No

Subscriber Name: _____ Relation to Patient: _____

Address (If different from patient's): _____ Phone: (___)_____

City: _____ State: _____ Zip: _____

Subscriber Employed by: _____ Business Phone: (____)_____

Insurance Company: _____ Soc. Sec #: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Names of other Dependents covered under this plan: _____

Fill in health information about your immediate family.

Patient Name: _____

Family History:

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations:

Year	Hospital	Reason for Hospitalization & Outcome

Pregnancies:

Year of Birth	Sex of Birth	Complications (if any)

Occupational:

Check (√), if your exposes you to:

	Stress
	Heavy Lifting
	Hazardous Substances
	Other

Health Habits:

Check (√) if you use, than indicate how much you use it.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Have you ever had a blood transfusion? □ **Yes** □ **No**
If yes, please give approximate dates _____.

Serious Illness/ Injury	Date	Outcome

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

X _____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

Confidential

Patient Name: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of last physical examination: _____

What is your reason for visit? _____

Symptoms - Check (√) symptoms you currently have or have had in the past year.

General
- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Loss of Sleep
- □ Loss of Weight
- □ Nervousness
- □ Numbness
- □ Sweats

Gastrointestinal
- □ Appetite poor
- □ Bloating
- □ Bowel changes
- □ Constipation
- □ Diarrhea
- □ Excessive hunger
- □ Excessive thirst
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal bleeding
- □ Stomach pain
- □ Vomiting
- □ Vomiting blood

Eye, Ear, Nose, Throat
- □ Bleeding gums
- □ Blurred vision
- □ Crossed eyes
- □ Difficulty swallowing
- □ Double vision
- □ Earache
- □ Ear Discharge
- □ Hay fevers
- □ Hoarseness
- □ Loss of hearing
- □ Nosebleeds
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems
- □ Vision – Flashes
- □ Vision – Halos

MEN only
- □ Breast lump
- □ Erection difficulties
- □ Lump in testicles
- □ Penis discharge
- □ Sore on penis
- □ Other

WOMEN only
- □ Abnormal Pap Smear
- □ Bleeding between periods
- □ Breast Lump
- □ Extreme menstrual pain
- □ Hot flashes
- □ Nipple discharge
- □ Painful intercourse
- □ Vaginal discharge
- □ Other

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram _____
Are you pregnant ___ Number of children ____

CARDIOVASCULAR
- □ Chest Pain
- □ Irregular Heart Beat
- □ Poor Circulation
- □ Swelling of ankles
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Rapid Heart Beat
- □ Varicose veins

GENITO-URINARY
- □ Blood in urine
- □ Frequent urination
- □ Lack of bladder control
- □ Painful urination

MUSCLE/JOINT/BONE
Pain, Weakness, Numbness in:
- □ Arms
- □ Back
- □ Feet
- □ Hands
- □ Hips
- □ Legs
- □ Neck
- □ Shoulders

SKIN
- □ Bruises
- □ Itching
- □ Scars
- □ Sores that won't heal
- □ Hives
- □ Rash
- □ Changes in moles

Condition

Patient Name: _____

Check (√) symptoms you currently have or have had in the past year.

- □ **AIDS**
- □ **Alcoholism**
- □ **Anemia**
- □ **Anorexia**
- □ **Appendicitis**
- □ **Arthritis**
- □ **Asthma**
- □ **Bleeding Disorders**
- □ **Breast Lump**
- □ **Bronchitis**
- □ **Bulimia**
- □ **Cancer**
- □ **Cataracts**
- □ **Chemical Dependency**
- □ **Chicken Pox**
- □ **Diabetes**
- □ **Emphysema**
- □ **Epilepsy**
- □ **Glaucoma**
- □ **Goiter**
- □ **Gonorrhea**
- □ **Gout**
- □ **Heart Disease**
- □ **Hepatitis**
- □ **Hernia**
- □ **Herpes**
- □ **High Cholesterol**
- □ **HIV Positive**
- □ **Kidney Disease**
- □ **Liver Disease**
- □ **Measles**
- □ **Migraine Headaches**
- □ **Miscarriage**
- □ **Mononucleosis**
- □ **Multiple Sclerosis**
- □ **Mumps**
- □ **Pacemaker**
- □ **Pneumonia**
- □ **Polio**
- □ **Prostate Problem**
- □ **Psychiatric Care**
- □ **Rheumatic Fever**
- □ **Scarlet Fever**
- □ **Stroke**
- □ **Suicide Attempt**
- □ **Thyroid Problems**
- □ **Tonsillitis**
- □ **Tuberculosis**
- □ **Typhoid**
- □ **Ulcers**
- □ **Vaginal Infections**
- □ **Venereal Disease**

Medications (List any medications you are currently taking)

_____
_____
_____
_____
_____
_____
_____
_____

Allergies

_____
_____
_____
_____
_____

Pharmacy Name: _____ **Phone:** _____

JFK Medical Associates

RARITAN BAY CARDIOLOGY GROUP
225 MAY STREET SUITE F
EDISON, NJ 08837
732.738.8855
FAX: 732.738.4141

Medical Records Consent

Physician Name: _____

Physician Address: _____

Patient Name: _____ Date: _____

Address: _____

SS#: _____

I hereby give consent for _____ to obtain my medical record from any medical
Physician's name(s)
facility for the purpose of review by above physician to coordinate my medical care.

Complete Medical Records: _____

Other (specify): _____

_____ _____
Patient Signature Date

Hackensack Meridian *Health*

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Our physicians and Staff are dedicated to assisting you to make sure that your health insurance has all of the information necessary to reimburse for all covered services. Your health insurance may not pay for all of your health care costs; you, your employer and your insurance company largely determine your health benefits. Health insurance only pays for covered items and services when their rules are met.

INSURANCE COVERAGE

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, you will be responsible for payment.

INSURANCE CHANGES

- If you have had any changes in your insurance coverage, please notify us. Failure to do so may result in a claim denial and you will be billed.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES

- Co-insurance and co-payments are the patient's/guarantor's responsibility. Co-payments are due at the time of the visit.
- Deductibles are the patient's/guarantor's responsibility. The deductible is determined by the contract you have with your health insurance carrier.

REFERRALS

- If your plan requires, it is your responsibility to obtain referrals from your Primary Physician prior to your visit. If you wish to be seen without the referral, payment is due at the time of visit.
- If you require a referral to a Specialist Physician please contact your Primary Physician at least one (1) business day before your appointment

INSURANCE REQUESTS

- You are responsible for responding to insurance company requests for further information.

INSURANCE PAYMENTS

- Any insurance payments sent to you should be forwarded to our Billing Office with a copy of the explanation of benefits (EOB) received.

RETURNED CHECK/NON-SUFFICIENT FUNDS

- A $25.00 fee will be assessed for any check returned for non-sufficient funds.

CANCELLATION/NO SHOW

- Cancel or reschedule your appointment at least 24 hours prior to your appointment. When a patient does not cancel or reschedule within 24 hours, a letter will be sent to the patient with an invoice for $25.00.

I have read and understand the terms of this Financial Responsibility form.

Date _____

Patient _____

Account Number _____

X _____

Patient/Gurantor Signature

New Jersey Department of Health
Vaccine Preventable Disease Program

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3. There is no cost to participate in this program.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH Vaccine Preventable Diseasearticipate in this program.
Program may be contacted at website or telephone number listed below:

P.O. Box 369
Trenton, NJ 08625-0369
Phone: (609) 826-4860
Fax: (609) 826-4866
www.njiis.nj.gov

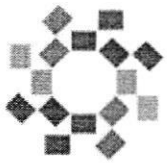
○ Yes, I would like to participate in this program.
○ No, I do not want to participate in this program.

Name of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)

Relationship to Registrant

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)

X



Hackensack
Meridian *Health*

Outpatient Consent Form

1. **Release of Information:** Hackensack University HealthPartners Medical Group may see, release or confirm, all or part of any financial and medical information, **including information regarding psychological, psychiatric, HIV and related diagnosis, drug and/or alcohol related illness**, with any person, corporation or government agency that is or may be responsible to Hackensack University HealthPartners Medical Group, the patient, and family member or employer for all or part of Hackensack University HealthPartners Medical Group's charges or verification of the same. I acknowledge that Hackensack University HealthPartners Medical Group may be required to release patient information, **including the highlighted above** to federal and state agencies that monitor healthcare facilities, as well as any industries that produce and/or manufacture medical products. I authorize Hackensack University HealthPartners Medical Group to provide access to my medical information to any person or organization in order to facilitate the provision of post visit care, treatment or services. I acknowledge that Hackensack University HealthPartners Medical Group may access patient information from my medical record for purposes of research. I acknowledge that I have been informed that I may be contacted to participate in a research study and that I have the right to agree or decline to participate.
2. **Assignment of Benefits:** I authorize my health insurance benefits to be paid directly to Hackensack University HealthPartners Medical Group. Under the terms of my policy this payment may not exceed the balance due for services performed during this period of treatment. I further authorize Hackensack University HealthPartners Medical Group to appeal on my behalf any denial by my insurance carrier.
3. **Medicare Payment Request:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administrator or its intermediaries or carriers any information needed for this or related Medicare claim. I request that direct payment of services on my behalf. I assign benefits payable for physicians' services to Hackensack University HealthPartners Medical Group.
4. **Outpatient Service "Medicaid":** I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for physician services to Hackensack University HealthPartners Medical Group or authorize Hackensack University HealthPartners Medical Group to submit a claim to Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

I have read the information contained above, any questions that had have been answered and I understand its contents. I attest that my personal information provided to Hackensack University HealthPartners Medical Group is correct. I understand that providing incorrect information for the purpose of avoiding payment or for any other reason may be considered a violation of state and/or federal law.

I understand that this form may be valid for the period of one year from the date signed for all physician services. I also understand that I have the right to ask questions at any time regarding my treatment, care or any terms contained in this consent. If I wish to revise my consent, I may do so by completing a new form or I wish to withdraw my consent, I must do so in writing.

X _____ _____ _____ _____

Patient **Date and Time** **Guarantor (if other than Patient)** **Date and Time**

_____ _____ _____

Next of Kin/Power of Attorney (if applicable) **Date and Time** **Relationship of Guarantor (if applicable)**

NOTICE OF PRIVACY PRACTICES RECEIPT
HACKENSACK MERIDIAN HEALTH

MRN#_____

I, _____, acknowledge receiving the Hackensack University Medical Center (HUMC) Notice of Privacy Practices. I also acknowledge that future revisions of this notice will be available on the HUMC website www.HackensackUMC.org or upon request.

- This pertains to the **HIPAA- NOTICE OF PRIVACY ACT GUIDELINES.** I have received the privacy act guidelines and listed all family members who can actively participate in my care planning. I understand that if I do not list these individuals; my patient information or the planning of my care will not be released or planned without my consent.

Name	Relationship	Phone#
Name	Relationship	Phone#
Name	Relationship	Phone#

Sign X_____

Date signed: _____
_____Patient
_____Legal Guardian

HackensackUMC Witness Name: _____

Witness Signature: _____
Date signed: _____

Effective Date: 9/15/2013