Affiliated Health Clinics New Jersey, LLC

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Age** | **Social Security Number** | **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other | **Language** other than English

Race ❑ Black – Non Hispanic ❑ American Indian/ Alaskan Native ❑ Hispanic ❑ Asian/Pacific Islander ❑ White – Non Hispanic ❑ Other

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Email Address | **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer | **Occupation** | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

How did you hear about us?

SPOUSE / PARTNER INFORMATION

Relationship to Patient ❑ Self (If self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Age** | **Social Security Number**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Employer | **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer Phone | **Occupation**

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Signature of Patient or Guardian _____ Date _____

Relationship to Patient _____ Witness Signature _____

Affiliated Health Clinics New Jersey, LLC

INSURANCE INFORMATION

Please present proof of insurance and valid identification upon completion of this form

Insurance Company: _____

Claims Address: _____

Street / PO Box City State Zip

Telephone Number: _____

Policy #: _____ **Group** # :_____

Insured Person: _____ **Relationship to Patient**: _____

Insured Person's Address: _____

Street City State Zip

Insured DOB: _____ / _____ / _____ **Insured S.S**.# : _____ - _____ - _____

Insured Employer : **Phone**: _____

~~Lifetime Assignment of Benefits and Information Release~~

_____
Patient Initials

I affirm that the billing and insurance information I have provided is correct to the best of my knowledge and I accept responsibility for keeping Affiliated Health Clinics informed of any changes to this information.

_____
Patient Initials

I authorize the release of my medical information including, without limitation of information related to psychiatric care, drug abuse, alcohol abuse, STD, or HIV/AIDS, confidential information that is needed for the submission to my insurance carrier in order to process a claim or for utilization review or quality assurance activities.

_____
Patient Initials.

I assign any and all medical and/or surgical benefits billed by Affiliated Health Clinics or one of thier provider to which I am entitled to Affiliated Health Clinics. A photocopy of this authorization shall be considered as valid as the original.

_____
Patient Initials

I agree to accept full responsibility for any copayments, deductible, coinsurance, and balances remaining after my insurance has processed claims, or for any services not covered or denied by my insurance company. If I do not have insurance coverage, I agree to pay in full for services provided at the time of service. I agree to be responsible for payment of any legal fees, court cost, and any and all other expenses incurred by or on behalf of Affiliated Health Clinics in pursuit of collecting fees due for services rendered.

_____
Patient Initials

I acknowledge and agree that copayments, deductible, coinsurance, and non-covered charges are due when services are rendered. I understand and agree to pay Affiliated Health Clinics a charge of $35 for failing to cancel an appointment without 24 hour notice or a no show to an appointment, and $50 above the value of a returned check plus any and all fees associated with collecting on the returned check.

Patient Signature: _____ Date: _____

Representative Signature:_____ Date: _____

Affiliated Health Clinics

www.ahcnewjersey.com

professional experienced care with a personal touch

Detailed Message

Dear Patient,

In accordance with the providers contracted by Affiliated Health Clinics blood may be drawn or other tests ordered and performed. We may contact you after your appointment with the results of your tests or to follow up on your care. We may also need to call in reference to your appointments and financial matters. In accordance with HIPAA regulations, we need your authorization to leave a detailed message or email for you with your results or questions in order to follow up on your care and financial matters, if we are unable to speak with you directly. Please select an option below.

___ I do not want you to leave a detailed message.

___ You can leave a detailed message at (_____) -_____-_____

or (_____) -_____-_____

You can email me at: _____

You can text appointment confirmations at (_____) - _____-_____

If there are any changes to the information above, you must notify our office in writing as soon as possible.
If you would like someone else to have access to your medical information and financial obligations to the office you may list their names below.

Authorized Person	Relationship to Patient
_____	_____
_____	_____
_____	_____

Patient Name_____(Please Print)

Signature_____Date_____

Affiliated Health Clinics

www.ahcnewjersey.com

professional experienced care with a personal touch

HIPAA PRIVACY POLICY ACKNOWLEDGE STATEMENT

I have been informed that Affiliated Health Clinics has a privacy policy in place according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient or parent / guardian of a patient at Affiliated Health Clinics, I understand the following:

1. Affiliated Health Clinics has a privacy policy in effect in our office.
2. Affiliated Health Clinics has made this policy readily available to me.
3. Affiliated Health Clinics has made me aware that I am entitled to a copy of this privacy policy if a desire a copy for my personal records.

After reading these statements please sign at the bottom of this sheet, acknowledging that you have been advised of the privacy policy implemented by Affiliated Health Clinics and have read and understand the acknowledgement form. If you would like a copy of the privacy policy please ask for one at the front desk or print in from our website www.ahcnewjersey.com

_____ No, I do not want a copy of the policy, but I do acknowledge that it exists

_____ Yes, I have requested and been given a copy of the privacy policy.

Patient Name:_____Acct #: _____

Patient Signature: _____

Parent / Guardian Signature: _____

For more information, please contact Affiliated Health Clinics Compliance and Privacy Officer at (727) 322-4227.

Affiliated Health Clinics New Jersey, LLC

NEW PATIENT HISTORY

1. IDENTIFYING INFORMATION

Name: _____ DOB: _____/_____/_____ Date: _____/_____/_____

Reason for visit: ☐ Preventative/ Well-Woman exam ☐ Other:_____
Age:_____ Marital Status: _____ Occupation:_____
Who referred you? _____
Name of internist or family doctor:_____
Name of last gynecologist:_____

2. MEDICATION HISTORY

List all medications and non-prescription medication that you take with the dose and timing, including vitamins, herbs, and anti-inflammatory medications: ☐ None

DRUG	DOSE	FREQUENCY	REASON FOR MEDICATION

Do you take hormone therapy or birth control pills? Please list dose and timing: ☐ None

_____
_____

Allergies: List all adverse reactions or allergies you have to medications and what happened ☐ None

_____
_____

3. MEDICAL HISTORY ☐ None

Please list any medical problems that you have, the physician taking care of you and how they are being treated.

DATE	MEDICAL PROBLEM	MEDICATION / TREATMENT	PHYSICIAN

Check if you currently have or have ever had:

Alcohol Abuse	☐	Depression / Anxiety	☐	Kidney Stones	☐
Anesthetic reaction	☐	Drug/Substance Abuse	☐	Lupus/Autoimmune Disorder	☐
Anemia	☐	Eating Disorder	☐	Mitral Valve Prolapse	☐
Asthma	☐	Heart Disease	☐	Rheumatic Fever	☐
Bleeding Disorder	☐	Hepatitis/Jaundice	☐	Seizure Disorder	☐
Blood Clots	☐	High Blood Pressure	☐	Stomach Ulcers	☐
Cancer	☐	High Cholesterol	☐	Stroke	☐
Chronic Lung Condition	☐	Hypothyroidism	☐	Transfusion Reaction	☐
Diabetes	☐	Irritable Bowel Syndrome	☐	Tuberculosis	☐

Please explain: _____
_____
_____

4. SURGICAL HISTORY ☐ None

List all surgeries you have had including but not limited to breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, wisdom teeth.

DATE OPERATION DIAGNOSIS HOSPITAL/ M.D.

_____

_____

_____

_____

5. GENERAL HEALTH

Date/Place of last pap smear: ☐ None _____
Date/Place of last mammogram: ☐ None _____
Date/Place of last blood work: ☐ None _____
Your Height _____feet _____inches Your weight _____lbs. Your blood type: _____
How much alcohol do you drink/week? ☐ None ☐ Avg. less than one daily ☐ Avg. one daily ☐ Avg. more
Do you smoke? ☐ Yes ☐ No Amount/Day _____ How many years? _____
If you quit smoking, when did you stop? _____
Have you used marijuana or other drugs in the last 5 years? ☐ Yes ☐ No Type:_____
Are you currently dieting or do you have a non-traditional diet? ☐ Yes ☐ No
Please Explain: _____
_____
Do you perform self-breast examinations monthly? ☐ Yes ☐ No
Have you been immunized or had the following? Hepatitis A ☐ Yes ☐ No Hepatitis B ☐ Yes ☐ No

6. GYNECOLOGIC HISTORY (Women Only)

Age of first menstrual cycle: _____ Date of last period:_____/_____/_____ ☐ Menopausal ☐ Hysterectomy
How frequently do you bleed? _____ How many days do you bleed? _____

What do you use to keep from getting pregnant? ☐ Nothing

☐ Abstinence	☐ Diaphragm	☐ Rhythm
☐ Birth Control Pills	☐ IUD	☐ Tubal Ligation
☐ Condoms	☐ Patch	☐ Vasectomy

Please check if you have had or currently have the following:

Abnormal Pap Smear	☐	Herpes	☐	Pelvic Adhesions	☐
Chlamydia	☐	HPV	☐	PMS	☐
Condyloma (Warts)	☐	HPV Gardasil Vaccine	☐	Recent Change in Period	☐
Cramps	☐	Incontinence of Urine	☐	Recurrent Vaginitis	☐
Endometriosis	☐	Laser/Freezing Cervix	☐	Syphilis	☐
Fibroids	☐	Mycoplasma/Ureoplasma	☐	Trichomonas	☐
Gonorrhea	☐	Ovarian Cyst	☐		

Sexual History:
Are you sexually active? ☐ Yes ☐ No Do you have pain with intercourse? ☐ Yes ☐ No

Infertility History: (complete if indicated)
How long have you been trying unsuccessfully to become pregnant? _____
How long have you been trying without any form of contraception? _____

Please describe any test/diagnosis/treatments you have had performed: _____
_____
_____
_____
_____
_____

Pregnancy History: ☐ No Pregnancies
Number of times pregnant _____ Full term births _____ Premature births _____
Elective termination _____ Miscarriage _____ Ectopic pregnancies _____

Early pregnancy loss: Please list date and length of pregnancy with outcome (less than 20 weeks)

DATE Miscarriage/# WEEKS ELECTIVE ABORTION/#WEEKS HOSPITAL/M.D.

_____
_____
_____

Deliveries: Please list date and length of pregnancy with outcome (lasting more than 20 weeks)

DATE # WEEKS VAGINAL/C-SECTION SEX/WEIGHT HOSPITAL/M.D. COMPLICATIONS

_____
_____
_____
_____

Family History: ☐ Adopted
Which of your 1st degree family members have the following:
Anesthesia Problems _____ Heart Disease _____
Breast Cancer _____ High Blood Pressure _____
Colon Cancer _____ Ovarian Cancer _____
Diabetes _____ Other Cancer _____

7. SYSTEMS REVIEW

Please check if you have had or currently have the following:

HEENT	**CURRENT**	**PAST**	**N/A**
Migraines	☐	☐	☐
Chronic Headaches	☐	☐	☐
Visual Changes	☐	☐	☐
Hearing Loss	☐	☐	☐
Dizziness	☐	☐	☐
CARDIOVASCULAR			
Chest Pain	☐	☐	☐
Chronic Cough	☐	☐	☐
Abnormal Chest X-Ray	☐	☐	☐
Leg Swelling	☐	☐	☐
Heart Murmur/Mitral Valve Prolapse	☐	☐	☐
Take Antibiotics for Dental Work	☐	☐	☐
Wheezing/Heart Palpitations	☐	☐	☐
GASTROINTESTINAL			
Chronic Abdominal Bleed	☐	☐	☐
Frequent Nausea/Vomiting	☐	☐	☐
Chronic Constipation	☐	☐	☐
Persistent Diarrhea	☐	☐	☐
Bloody Stools	☐	☐	☐
Hemorrhoids	☐	☐	☐

NEUROLOGIC	**CURRENT**	**PAST**	**N/A**
Any Neurological Disorders	☐	☐	☐
Fainting	☐	☐	☐
Numbness	☐	☐	☐
Weakness	☐	☐	☐
Head/Nerve Injury	☐	☐	☐
Anxiety/ Depression	☐	☐	☐
BREAST			
Breast Lump	☐	☐	☐
Breast Tenderness	☐	☐	☐
Breast Secretion	☐	☐	☐
Bleeding from Nipples	☐	☐	☐
Breast Implants	☐	☐	☐
URINARY			
Recurrent Urinary Tract Infections	☐	☐	☐
Blood in Urine	☐	☐	☐
Painful Urination	☐	☐	☐
Kidney Stones	☐	☐	☐
HEMATOLOGY			
Frequent Bruising	☐	☐	☐
Cuts that Do Not Stop Bleeding	☐	☐	☐
Enlarged Lymph Nodes	☐	☐	☐

Please explain: _____
_____
_____
_____
_____
_____