PSONJ
PHYSICIAN SPECIALISTS OF NORTHERN JERSEY

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Birth Date: _____ Gender: □ Male □ Female Marital Status: □ S □ M □ D □ L.S. □ W

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____ □ Unemployed □ Retired □ Disabled

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Insurance: _____ Member ID#: _____ Group #: _____

Subscriber Name: _____ DOB: _____ Your Relationship to Subscriber: _____

Secondary Insurance: _____ Member ID#: _____ Group #: _____

Subscriber Name: _____ DOB: _____ Your Relationship to Subscriber: _____

Referring Provider: _____ City: _____ Phone #: _____

Or, how were you referred to our office? □ A Friend □ Another Patient □ Insurance Listing/Website □ Urgent Care □ Referral Service

Primary Care Provider: _____ City: _____ Phone #: _____

Please list any other Specialist Physicians you currently see:

Name: _____ City: _____ Phone: _____

Name: _____ City: _____ Phone: _____

Name: _____ City: _____ Phone: _____

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Physician Specialists of Northern Jersey is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care provider that jointly perform payment activities and business operations with our Practice. "Protected Health Information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical, mental health or condition and related health care services. **PLEASE FEEL FREE TO REQUEST A COPY.**

_____ Date: ____/____/____
Signature of Patient/ Health Care Agent/ Guardian/ Relative
(This signature indicates you were offered/received a copy of the Notice of Privacy Practices.)

□ Patient is unable to sign due to medical reason □ Patient refuses to sign

E-RX PRESCRIBING CONSENT

PSONJ utilizes ePrescribing in our office. ePrescribing is a federally mandated initiative which requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet, safely and securely to your pharmacy, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software also lets your doctor see important information such as drug interactions and medication history. The benefits to you: Reduced possibility of medical errors, less chance of adverse drug reactions, fewer trips to the pharmacy since Rx drop off is mostly eliminated, and a faster/simpler way to get your prescription filled. **I agree that PSONJ may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.**

Patient Signature: _____ Date: ____/____/____

Michael Gross, MD • Jason Shatkin, MD • Jennifer Porco, APN • Elizabeth Heydt, APN
1 Sears Drive Ste 306, Paramus, NJ 07652 • P: 201-830-2287 F: 201-830-2286

ADDITIONAL INFORMATION

Ethnicity: ◻ Hispanic ◻ Non-Hispanic **Language:** ◻ English ◻ Spanish ◻ Other: _____

Race: American Indian/Alaska Native Asian Asian Indian Hawaiian Black/African American White/Caucasian Hispanic/Latino Other Pacific Islander Other Decline to specify

Email Address: _____ (By listing your email address, you opt to receive an invitation with log-in credentials to sign up for our Patient Portal as well as receive Appointment reminders, Billing statements, etc.)

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____

Please select your preferred laboratory: ◻ Labcorp ◻ Quest ◻ BioReference ◻ Other _____

Your preferred Diagnostic Imaging Center: _____

Please list anyone that we are allowed to speak to regarding your medical records:

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

MEDICAL HISTORY: CURRENT & PAST

Reason for today's visit: _____

How long has the problem, condition, or pain been present? _____

Please rate the severity of your pain, if any: ◻ Slight ◻ Moderate ◻ Severe ◻ N/A

Please list current medications (Please include vitamins, supplements, herbs, 'natural medicines', etc. or attach a list if necessary)

Medication Name	**Dose (# of mg/kg/etc.)**	**Frequency (times per day/wk/etc.)**

Do you have any allergies to medications? ◻ Yes ◻ No

If Yes, please list: _____

Do you have a Living will? ◻ Yes ◻ No

Do you have a Power of Attorney? ◻ Yes ◻ No

If Yes, please list: Name: _____ Phone: _____

Please list any prior Major Illnesses, Injuries, Surgeries/Hospitalizations (and the year):

_____

_____

Immunization/Vaccination History:

Have you ever received a Pneumonia vaccine? ◻ No ◻ Yes

If Yes, which one? Pneumovax (Date/Year): _____ Prevnar13 (Date/Year): _____

Have you recently received an Influenza vaccine? ◻ No ◻ Yes - Approximate Date? _____

Have you received any of the COVID-19 vaccines? ◻ No ◻ Yes **If yes, which one?** ◻ Pfizer ◻ Moderna ◻ Janssen

Dose #1 Date: _____ Dose #2 Date: _____

1st Booster (Dose #3) Brand Name and Date if given: _____

2nd Booster (Dose #4) Brand Name and Date if given: _____

3rd Booster (Dose #5) Brand Name and Date if given: _____

COVID-19 Bivalent Booster (Brand Name and Date): _____

Please describe your family history and check off any illnesses that are applicable:

Mother: □ Alive □ Deceased □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer

Father: □ Alive □ Deceased □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer

Siblings: □ N/A # of Brothers: ____ # of Sisters: ____

□ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer

Children: □ N/A # of Sons: ____ # of Daughters: ____

Do you currently smoke cigarettes, cigars, and/or chew tobacco? □ No □ Yes Quantity per day? _____

Are you a former smoker? □ No □ Yes How long ago did you quit? _____

Did you have a drink containing alcohol in the past year? □ No □ Yes

If yes, how often did you have an alcoholic beverage within the past year?

□ Never □ Monthly or Less □ 2-4x a month □ 2-3x a wk □ 4 + times a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year?

□ 1-2 □ 3-4 □ 5-6 □ 7-9 □ 10 or more

If yes, how often did you have 6 or more drinks on one occasion in the past year?

□ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

Depression Screening: In the past 2 weeks have you experienced the following?

a. Do you have little interest or pleasure in doing things? □ Not at all □ Several days □ More than 50% of the time □ Almost everyday

b. Do you feel down, depressed, or hopeless? □ Not at all □ Several days □ More than 50% of the time □ Almost everyday

Please circle any of the following conditions/symptoms you have had or currently have:

Eyes
- Infections/Injuries
- Glaucoma
- Cataracts

Ear/Nose/Throat
- Sinusitis
- Hearing Loss
- Ear Pain / Infections
- Ringing in Ears
- Vertigo/Balance issues
- Nosebleeds
- Nasal Congestion
- Frequent Sore Throat
- Mouth Sores

Cardiovascular
- Pacemaker
- Heart Disease
- Atrial Fibrillation
- Chest Pain/Angina
- High Blood Pressure
- Heart Attack
- Heart Murmur
- Swelling in Feet or Hands
- High Cholesterol
- Stroke/TIA
- Aortic Aneurysm

Respiratory
- Asthma
- Chronic Cough
- Emphysema
- Shortness of Breath
- Bronchitis
- Pneumonia
- Lung Cancer
- Bloody Sputum
- Sleep Apnea

Genitourinary
- Urinary Tract Infections
- Painful Urination
- Blood in Urine
- Uterine/Cervical Cancer
- Kidney Stones
- Urinary Incontinence
- Prostate Cancer
- Endometriosis

Musculoskeletal
- Gout
- Disc Herniation
- Arm or Leg Weakness
- Back Pain
- Joint Pain or Swelling
- Arthritis
- Osteoporosis
- Fibromyalgia

Neurological
- Seizures
- Memory Issues
- Disorientation
- Speech Difficulty
- Inability to Concentrate
- Double/Blurred Vision
- Face Weakness
- Coordination in Arms/Legs
- Epilepsy

Gastrointestinal
- Indigestion/Pain with Eating
- Nausea / Vomiting
- Diverticulitis
- Liver Disease
- GERD
- Abdominal Pain
- Change in Bowel Habits
- Ulcers/Gastritis
- Colon Cancer

Endocrine
- Diabetes
- Thyroid Disorder/Disease
- Increased Appetite
- Excessive Thirst
- Hormone Imbalance
- Cushing's Disease

Allergic/Immunologic
- Food Allergies
- Environmental Allergies
- Immunologic Disorders

Hematologic/Lymph
- Anemia
- Hepatitis
- Blood Clots
- Swollen Glands/Lymph Nodes
- Blood Transfusion
  - If yes, when _____

Constitutional
- Fever
- Weight Loss
- Excessive Fatigue
- Night Sweats
- Headache

Psychiatric
- Anxiety
- Depression
- Psych disorder

Integumentary
- Skin Cancer
- Skin Disease

PATIENTS AGED 65 and older: Have you had any falls in the past year?

□ No □ 1 fall with injury □ 2 or more falls with injury □ 1 fall without injury □ 2 or more falls without injury

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Financial Policy Consent Form

PSONJ is committed to providing you with high quality medical care and we would like to keep you informed about your financial responsibilities for healthcare services. It is the patient's responsibility to provide accurate and complete insurance information before each office visit, including coordination of benefits. It is also important to alert our staff if you have any insurance plan changes or a new ID card. If you provide us with a secondary insurance, we will automatically submit a claim to the plan after the primary carrier has paid. You are financially responsible for any services provided but not covered by your health plan as stated on your insurance Explanation of Benefits. It is PSONJ's policy to treat each of our patients as fairly and equally as possible in relation to collection of copayments, coinsurance, deductibles, and any other account balances. Our staff is always available if you have any questions or need to discuss insurance coverage, your out-of-pocket cost for services, etc.

- Please make sure to present your insurance card(s) to our front desk when checking in for your appointment.
- All **copayments** must be collected at time of service before you see your physician. This is required as stated by your insurance company and is your responsibility as listed on your insurance card. Any previous outstanding balances from prior visits must also be collected before seeing your physician.
- If you have a **high-deductible** insurance plan, we may request a credit card to be kept on file (in a secure/locked file) for services rendered by your physician. Once your insurance processes the claim and a balance for the visit is applied to your account as your responsibility, we will inform you and charge the credit card to pay the remaining balance you are responsible for. If you do not agree to present a credit card, we require a $100-$200 deposit to be paid at the time of each visit until your plan deductible has been met. This payment will be applied to your account balance after we submit to the insurance, and you will receive a bill if there is any amount remaining.
- All Deductibles, Co-Insurances, Self-Pay payments and etc. are due at the time of your appointment before you see your physician. If you have an outstanding balance in excess of 30 days, PSONJ may contact you to cancel any future appointments until a payment can be made. We do not offer payment plans.
- As a respect to your physician and other patients in need, we require a 24-hour notice if you need to cancel your appointment. Failure to show for an appointment or give us 24-hr notice for a cancellation (same-day cancellations) will leave you responsible for a **$50 No-Show Fee**. New Consults/Procedures will be charged a $100 No-Show fee. After more than 2 continuous No Shows or same-day cancellations, your physician reserves the right to request a credit card to be kept on file. This will be charged in the event of any future No Show or last-minute cancellation. Our practice also reserves the right to discharge a patient from our practice for frequent No Shows or cancellations.

I CERTIFY THAT I HAVE READ AND UNDERSTAND PSONJ'S FINANCIAL POLICIES AND AGREE TO THE TERMS STATED ABOVE.

Patient Signature: _____ Date: _____

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