Sovereign Medical Group

DEMOGRAPHICS		
	NAME:	*FIRST* *M.I.* *LAST*
	ADDRESS:	
	CITY/ STATE/ ZIP:	
	HOME PHONE:	
	CELL PHONE:	
	WORK PHONE:	
	PRIMARY CARE PHYSICIAN:	
	HOW DID YOU HEAR ABOUT OUR OFFICE:	□ ANOTHER PROVIDER: NAME: ____________________ CITY/STATE: ____________________ □ ONLINE – SEARCH ENGINE/WEBSITE: ____________________ □ PATIENT
	DATE OF BIRTH:	**SEX:** □ F □ M **SSN:**
	MARITAL STATUS:	□ SINGLE □ MARRIED □ PARTNER □ WIDOWED □ DIVORCED □ SEPARATED
	EMERGENCY CONTACT:	*NAME:* *RELATION:* *PHONE #:*

IF WE COLLECTED YOUR INSURANCE CARD(S), ONLY FILL IN THE SUBSCRIBER NAME, RELATION, AND DATE OF BIRTH IF IT IS NOT SELF.

INSURANCE		
	PRIMARY:	
	SUBSCRIBER ID:	
	GROUP NO:	
	SUBSCRIBER (IF NOT SELF):	*NAME:* *RELATION:* *DATE OF BIRTH:*
	SECONDARY:	□ N/A
	SUBSCRIBER ID:	
	GROUP NO:	
	SUBSCRIBER (IF NOT SELF):	*NAME:* *RELATION:* *DATE OF BIRTH:*

NOTICE OF PRIVACY PRACTICES		
	PLEASE READ:	*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.* Sovereign Medical Group 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 that relates to your past, present or future physical or mental health or condition and related health care services. **PLEASE REVIEW IT CAREFULLY.** This signature indicates you were offered /received a copy of the Notice of Privacy Practices.)
	DATE:	
	SIGNATURE:	**X**
		□ *PATIENT UNABLE TO SIGN DUE TO MEDICAL REASON* □ *PATIENT REFUSES TO SIGN*

E-RX CONSENT		
	PLEASE READ:	Sovereign Medical Group implements ePrescribing at our office. ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, 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, like drug interactions and prescription history. The benefits to you are reduced possibility of medical errors, less chance of adverse drug reactions, fewer trips to drop off at the pharmacy and a safer, faster, easier way to get your prescription filled. **I agree that Sovereign Medical Group may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.**

PRINT NAME (FIRST, M.I., LAST): ______________________________

	DATE:		SIGNATURE:	x

Do you have an Advance Healthcare Directive?: □ NO □ YES

PLEASE PROVIDE THE OFFICE WITH A COPY WHEN POSSIBLE.

ADDITIONAL INFORMATION		
	EMAIL ADDRESS:	
	RACE:	□ AMERICAN INDIAN □ ASIAN □ NATIVE HAWAIIAN/PACIFIC ISLANDER □ AFRICAN AMERICAN □ WHITE □ HISPANIC □ OTHER RACE □ OTHER PACIFIC ISLANDER □ REFUSE TO REPORT
	ETHNICITY:	□ HISPANIC □ NOT HISPANIC □ REFUSE TO REPORT
	LANGUAGE:	
	PHARMACY (NAME/CITY):	

FINANCIAL RESPONSIBILITY:				
	PLEASE READ:	**FINANCIAL RESPONSIBILITY:** You are responsible to supply our staff with your insurance ID cards. We will automatically file the claim for you; however, you are responsible for any deductible or co-pay due at the time of service as described by your insurance policy. If any of the procedures performed here are not covered under your plan, you will be financially responsible for full payment. You hereby guarantee payment in full to Sovereign Medical Group for all charges for serves rendered and/or charges exceeding third party payments (except when prohibited by law or under contract). You also authorize Sovereign Medical Group to release to government agencies insurance carriers and others who may be financially liable for the services, all information necessary to pre-authorize services, determine medical necessity and/or the extent or amount of liability and challenge denials of medical necessity. You hereby assign all amounts payable for services rendered to Sovereign Medical Group. You understand that this constitutes a waiver of confidentiality under 42 C > F.R. part 2 (drug and alcohol records) and N.J.S.A. 26: 5c-1 et seq. (FTW and AIDS records) and that this authorization is revocable, except to the extent that action has been taken in reliance thereon and will otherwise remain in force indefinitely in order to effectuate the purpose for which it is given. It is your responsibility to understand which insurance plans SMG participates with. The bill is your responsibility. Your insurance policy is a contract between you and your insurance company. Our office is not a part of the contract. We are happy to file your claim for you directly with you insurance company; however, the ultimate responsibility for payment is yours. You certify that the information given to you in applying for payment under the Title XVIII of the Social Security Act is correct. You authorize any holder of medical or other information to release to the Social Security Administration or its intermediaries or carries the information necessary for this or related to the Medicare claim. You request that payment of authorize benefits be made on your behalf. You hereby request and consent to, examination and treatment (including lab procedures, diagnostic and medical/surgical) rendered by Sovereign Medical Group and their associates. You also consent to the removal of specimens taken by lab or pathology examination. It is your responsibility to understand which lab your insurance company affiliates with. Our office will not be held liable for services rendered to you by a non-participating lab. We accept cash, check, money order, and credit cards. There is a $25.00 fee for any returned check. Please be aware in the event your bill remains unpaid, we are forced to use a collection agency and you will be responsible for all costs associated with the process. Do not hesitate to call our office with any billing questions or concerns. Phone: (201) 703-5500. PLEASE NOTE: IF YOU DO NOT SHOW FOR YOUR SCHEDULED APPOINTMENT(S) WITHOUT CALLING THE OFFICE TO CANCEL/RESCHEDULE, YOU WILL BE CHARGED $25. **I certify that I have read this form and understand its contents. I also acknowledge no guarantees have been made to me as to the results of exams or treatment.**		
	DATE:		**SIGNATURE:**	x

MEDICAL HISTORY					
	REASON FOR TODAY'S VISIT:				
	HEIGHT:		**WEIGHT:**		
	LOCATION OF PAIN:		**DURATION OF PROBLEM (PAIN):**		
	QUALITY OF PAIN:	□ SHARP □ BURNING □ DULL □ ACHING		**SEVERITY OF PAIN:**	□ MILD □ MODERATE □ SEVERE
	ASSOCIATED SIGNS/SYMPTOMS:				
	LIST ALL CURRENT/PAST MEDICAL ISSUES:				
		□ NO □ YES			

PRINT NAME (FIRST, M.I., LAST): ____________________

	ALLERGIES TO MEDS/FOOD?:	*IF YES, PLEASE LIST:*

PLEASE LIST ALL MEDICATIONS & VITAMINS, YOU ARE TAKING:

CURRENT MEDICATION(S)	*MEDICATION*	*DOSE*	*FREQUENCY*

MEDICAL HISTORY

PAST SURGERIES:			
PAST HOSPITALIZATIONS:			

FAMILY HISTORY

MOTHER:	☐ ALIVE ☐ DECEASED	**HEALTH ISSUES:**
FATHER:	☐ ALIVE ☐ DECEASED	**HEALTH ISSUES:**

SIBLING(S):	☐ N/A		
	BROTHER(S):	HOW MANY:	HEALTH ISSUES:
	SISTER(S):	HOW MANY:	HEALTH ISSUES:
CHILDREN:	☐ N/A		
	SON(S):	HOW MANY:	HEALTH ISSUE(S):
	DAUGHTER(S):	HOW MANY:	HEALTH ISSUE(S):

SOCIAL HISTORY

DO YOU SMOKE CIGARETTES, CIGARS, AND/OR CHEW TOBACCO? ☐ NO ☐ YES	***IF NO, DID YOU USED TO?*** ☐ NO ☐ YES ***APPROXIMATELY WHEN DID YOU QUIT?:***
IF YES, HOW OFTEN DO YOU SMOKE?: ☐ EVERY DAY ☐ MOST DAYS	**QUANTITY PER DAY:**

HAVE YOU HAD ANY ALCOHOLIC BEVERAGE IN THE PAST YEAR?: ☐ NO ☐ YES

IF YES, HOW OFTEN DID YOU CONSUME AN ALCOHOLIC BEVERAGE WITHIN THE PAST YEAR:

☐ MONTHLY OR LESS ☐ 2 -4 X A MONTH ☐ 2-3x A WEEK ☐ 4+ TIMES A WEEK

Have you recently received an influenza vaccine? ☐ NO ☐ YES ***IF YES, APPROXIMATELY WHEN (month/year)?:***

PRINT NAME (FIRST, M.I., LAST): ____________________

Have you ever received a pneumonia vaccine? ☐ NO ☐ YES *IF YES, APPROXIMATELY WHEN (month/year)?:*
If you have had a mammogram, please write an approximate date (month/year):
If you have had a colonoscopy, please write an approximate date (month/year):
PATIENTS AGED 65+: HAVE YOU HAD ANY FALLS IN THE PAST YEAR? ☐ No ☐ One fall with injury ☐Two or more falls with injury ☐ One fall without injury ☐ Two or more falls without injury

PLEASE CHECK OFF ANY OF THE FOLLOWING ISSUES YOU'VE HAD OR CURRENTLY HAVE:

SYMPTOMS/ILLNESSES		
	CONSTITUTIONAL:	☐ RECENT WEIGHT CHANGE ☐ FEVER ☐ FATIGUE ☐ HEADACHES
	EYES:	☐ EYE DISEASE ☐ INJURY ☐ CORRECTIVE LENS ☐ BLURRED/DOUBLE VISION ☐ GLAUCOMA
	ENT:	☐ HEARING LOSS ☐ RINGING IN EARS ☐ EARACHES OR DRAINAGE ☐ RHINITIS ☐ NOSEBLEEDS ☐ MOUTH SORES ☐ BLEEDING GUMS ☐ BAD BREATH/TASTE ☐ SORE THROAT/VOICE CHANGE
	CARDIOVASCULAR:	☐ ANGIOPLASTY/BYPASS ☐ PALPITATIONS/ARRHYTHMIA ☐ SWELLING OF EXTREMITIES
	GASTRO:	☐ BLOOD IN STOOL ☐ LOSS OF APPETITE ☐ CHANGE IN BOWEL MOVEMENTS ☐ NAUSEA/VOMITTING ☐ HEARTBURN ☐ ACID REFLUX ☐ DIARRHEA ☐ BLOATING ☐ BELCHING ☐ ABDOMINAL PAIN ☐ PEPTIC ULCER
	GENITOURINARY:	☐ ERECTILE DYSFUNCTION ☐ FREQUENT URINATION ☐ BURNING/PAINFUL URINATION ☐ BLOOD IN URINE ☐ INCONTINENCE ☐ CHANGE IN FORCE OF STREAM ☐ KIDNEY STONES
	RESPIRATORY:	☐ ASTHMA ☐ SPITTING UP BLOOD ☐ SHORTNESS OF BREATH ☐ WHEEZING
	MUSCULOSKELTAL:	☐ DIFFICULTY WALKING ☐ JOINT PAIN/ STIFFNESS ☐ JOINT SWELLING ☐ MUSCLE PAIN/CRAMPS ☐ BACK PAIN ☐ DISC DISEASE ☐ COLD EXTREMITIES
	INTEGUMENTARY:	☐ BREAST PAIN, LUMP, DISCHARGE ☐ RASH/ITCHING ☐ CHANGE IN SKIN COLOR
	NEUROLOGICAL:	☐ STROKE ☐ FREQUENT HEADACHES ☐ LIGHTHEADED/DIZZINESS ☐ SEIZURES ☐ NUMBNESS/TINGLING ☐ TREMORS
	PSYCHIATRIC:	☐ INSOMNIA ☐ MEMORY LOSS, CONFUSION ☐ LOSS OF INTERESTS ☐ DEPRESSION ☐ ANXIETY
	ENDOCRINE;	☐ HEAT/COLD INTOLERANCE ☐ HORMONE ISSUES ☐ THYROID DISEASE ☐ DIABETES ☐ EXCESSIVE THIRST
	HEME/LYMPH:	☐ PHLEBITIS ☐ BLOOD TRANSFUSION ☐ PROLONGED HEALING, BLEEDING, BRUISING ☐ ANEMIA

CHECK OFF		
	DO YOU HAVE LITTLE INTEREST OR PLEASURE IN DOING THINGS?	☐ NO ☐ YES
	DO YOU FEEL DOWN, DEPRESSED OR HOPELESS?	☐ NO ☐ YES

OVER THE LAST TWO WEEKS, HOW OFTEN HAVE YOU EXPERIENCED THE FOLLOWING? :
LITTLE INTEREST/PLEASURE IN DOING THINGS: ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day
FEELINGS DOWN, DEPRESSED, OR HOPELESS: ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day
TROUBLE FALLING OR STAYING ASLEEP / SLEEPING TOO MUCH: ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day
FEELING TIRED OR HAVING LITTLE ENERGY: ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day
POOR APPETITE / OVERATING: ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day
FEELING BAD ABOUT YOURSELF OR THAT YOU'RE A FAILURE, OR HAVE LET YOURSELF OR YOUR FAMILY DOWN: ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day

PRINT NAME (FIRST, M.I., LAST): ____

TROUBLE CONCENTRATING ON THINGS, SUCH AS READING THE NEWSPAPER OR WATCHING TV: □ Not at all □ Several Days □ More than half the days □ Nearly every day
MOVING OR SPEAKING SO SLOWLY THAT OTHER PEOPLE COULD HAVE NOTICED ; OR THE OPPOSITE, BEING SO FIDGETY OR RESTLESS THAT YOU HAVE BEEN MOVING AROUND A LOT MORE THAN USUAL: □ Not at all □ Several Days □ More than half the days □ Nearly every day
THOUGHTS THAT YOU WOUL BE BETTER OFF DEAD, OR OF HURTING YOURSELF IN SOME WAY: □ Not at all □ Several Days □ More than half the days □ Nearly every day