To Our New Patient:

The Physicians of Hunterdon Cardiovascular Associates would like to welcome you to our practice. Enclosed you will find a Patient Information form, a Health History form and a Medical Release form. The Patient Information and Health History forms should be completed at home and presented at the time of your visit at check in.

The Medical Records Release form should be sent to the physician or hospital that has in its possession pertinent medical records detailing the care and treatment rendered for your heart problem.

Please be sure to bring the following to your first appointment:

- Driver's License
- Insurance Card
- New patient forms enclosed
- Any recent health related documents: Recent office note from your referring physician, EKG, Stress Test, Echocardiogram, Cardiac Catheterization, Angioplasty, Bypass Surgery or Vascular Surgery.

Our office will work toward requesting your medical records from the surrounding area. However, there is no guarantee that we will receive it in time for your upcoming appointment. It is important that you contact any and all facilities or doctors' offices to request that your records be sent to our office by your appointment date.

We look forward to meeting you, Please remember to arrive 30 minutes before your appointment.

Very Truly Yours,

The Physicians of Hunterdon Cardiovascular Associates

HUNTERDON CARDIOVASCULAR ASSOCIATES, P.A.

Patient Information

Last Name _____ First Name _____ M.I. _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Social Security # _____ Birth Date _____ Race _____ Ethnicity _____

Home Phone (____) _____ Cell Phone # (____) _____ Work Phone # (____) _____ Ext. _____

Marital Status ❑ Single ❑ Married Email _____ Sex ❑ Male ❑ Female

Insurance Information - Primary / Secondary / Other

Please Give Your Insurance Cards To The Receptionist

Is this office visit related to a workman's compensation case? ❑ Yes ❑ No or Motor vehicle accident? ❑ Yes ❑ No

Do you have health insurance? ❑ Yes ❑ No Copay ❑ Yes ❑ No Amount $_____

Primary Insurance _____

Address _____

Policy No. _____

Group No. _____

Please indicate policyholder for primary insurance: ❑ Self ❑ Spouse

Copay ❑ Yes ❑ No Amount $ _____

Secondary Insurance _____

Address _____

Policy No. _____

Group No. _____

Please indicate policyholder for secondary insurance: ❑ Self ❑ Spouse

Copay ❑ Yes ❑ No Amount $ _____

Pharmacy Information

Pharmacy Name _____ City _____ State _____ Phone _____

Patient's Employer Information

Employer's Name _____ Patient's Occupation _____

Address _____ City _____ State _____ Zip _____ Telephone # _____

Policy Holder's Information (If other than Patient)

Name _____ Birth Date _____

SS# _____ Employer's Phone # (____) _____

Employer _____

Employer's Address _____ State _____ Zip _____

Emergency Information

In case of an emergency, we may contact: _____

Phone # (____) _____ Relationship to Patient _____

Primary Care / Referring Physician Information

Your Primary Care Physician's Name: _____ Telephone # _____

Address _____ Release Information to PCP? ❑ Yes ❑ No

Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to Hunterdon Cardiovascular Associates, its successors and assigns, or any individual it may designate for services provided.

I hereby agree that I am financially responsible to Hunterdon Cardiovascular Associates, for all Copays, coninsurance, deductibles and fees for non-covered services which are rendered to me.

Signature of Patient or Parent of Minor Date

Authorization for Medicare

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Hunterdon Cardiovascular Associates, for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medical Services and its agents any information needed to determine these benefits or the benefits payment for related services.

Signature of Patient or Parent of Minor Date

PATIENT INFORMATION FORM

Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and health care operations (as defined in the Notice). We may leave messages on your answering machine; we may call your place of employment to give you information about your visit; we may discuss your care with a caregiver who brings you to our office, or to relatives that have shown interest in your care; we may discuss your medications, blood work, tests results with you on the phone or at our nurses station; we may schedule appointments for follow-up visits or diagnostic tests while you are in our check out area. If this is understood and agreeable, please sign and date below:

Signature _____ Date _____

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name _____ Birthdate _____ Patient # _____

Chief Complaint: _____

History of Present Illness:

Location _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms

Modifying factors

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back Trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray _____			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes			
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes			
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (Include nonprescription):

Patient social history:

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of tobacco: Never: _____ Previously, but quit: _____ Current packs/day: _____

Use of drugs: Never: _____ Type/Frequency: _____

Excessive exposure at home or work to: Fumes: _____ Dust: _____ Solvents: _____ Air-borne Particles: _____ Noise: _____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

(OVER)

Item 056-7149/16788 Patterson Office Supplies 800-637-1140

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

☐ **Eyes**

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

☐ **Ears/Nose/Mouth/Throat**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

☐ **Cardiovascular**

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

☐ **Respiratory**

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

☐ **Gastrointestinal**

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

☐ **Genitourinary**

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes
Female - # of pregnancies	_____	
Female - # of miscarriages	_____	
Female - date of last pap smear	_____	

☐ **Musculoskeletal**

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

☐ **Integumentary (skin, breast)**

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

☐ **Neurological**

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head injury	No	Yes

☐ **Psychiatric**

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

☐ **Endocrine**

Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

☐ **Hematologic/Lymphatic**

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate or other antiseptic	No	Yes

Other drugs/medications:

Known food allergies:

Environmental allergies:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

HUNTERDON CARDIOVASCULAR ASSOCIATES

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of ____Hunterdon Cardiology____ not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: ________________________ ____yes ____ no Ph# ________________

Parent: ________________________ ____yes ____ no Ph# ________________

Other: ________________________ ____yes ____ no Ph# ________________

________________________ ____yes ____ no Ph# ________________

________________________ ____yes ____ no Ph# ________________

Phone: ________________________

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

Okay to leave a voicemail? ☐ YES ☐ NO

PRINTED NAME ______________________________ **D.O.B.** ______________

Patient/Parent/Guardian Signature: ____________________________________

Date: ________________________

By my signature, I acknowledge that I have received the Notice of Privacy Practices of Hunterdon Cardiovascular Associates, P.A.

- -

FOR OFFICE USE

Changes to above authorized by patient over phone:

Change	Date	Staff Initials
____________________________	______	______
____________________________	______	______
____________________________	______	______

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME:_____ **DOB:**_____

I hereby authorize ☐ Hunterdon Cardiovascular Associates, 1100 Wescott Drive, Suite G-3, Flemington, NJ 08822

☐ _____

Physician/Facility

_____

Street, City, State, Zip Code

To Disclose:

☐My medical records and information pertaining to my medical history, mental or physical condition, services rendered or treatment.

☐The medical records and information belonging to this patient for whom I have authorization (copy of authorization to be attached) pertaining to his/her medical history, mental or physical condition, services rendered or treatment.

TO: ☐ Hunterdon Cardiovascular Associates, 1100 Wescott Drive, Suite G-3, Flemington, NJ 08822

☐_____

Physician/Facility

_____

Street, City, State, Zip Code

The authorization is limited to the following medical records and types of information:

☐Office visit notes
☐EKG
☐Nuclear cardiac study
☐Echocardiogram
☐Blood results
☐Cath report
☐All medical records
☐Other procedures
☐Insurance information
☐Other

USES:

The person requesting this information may use this information only for the following purposes:

DURATION:

This authorization is effective immediately and shall remain in effect until:_____.

RESTRICTIONS:

I understand that the requestor of this information may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY:

I further understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: ☐Yes ☐No Initial:_____

SIGNATURES:

_____ _____

PATIENT/GUARDIAN, REPRESENTATIVE/SPOUSE**FINANCIALLY RESPONSIBLE** DATE

_____ _____

WITNESS DATE

**A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a non-profit hospital plan, a health care service, plan or an employee benefit plan.

FINANCIAL AND INSURANCE POLICY

Hunterdon Cardiology

&

Hunterdon Cardiovascular Associates

Our practice participates with Medicare, Horizon Blue Cross Blue shield, Aetna, Cigna, Multiplan, Beechstreet, Oxford, United Operating Engineers, PHCS, Qualcare, Amerihealth, Keystone and Medicaid.

Private Pay: Payment for services rendered in our offices is due at the time of service. This includes all insurance plans that we do not participate with. For self-pay patients with no insurance or with an insurance plan we don't participate with, a 15% discount is applied if payment in full is made at the time of service. In addition, medically necessary services not covered by your insurance plan are eligible for a 15% discount when paid in full at the time of service.

Managed Care Insurance Contracts: Patients enrolled in managed care health plans are ***required*** to pay their co-pays and present valid referrals at the time of service. After insurance has paid for services, co-insurance amounts are due upon receipt of bill. Payment can be made via phone calls to the billing department with Visa or Master Card.

Acceptable Methods of Payment: Cash Visa Money Order Check Master Card

*A receipt will be provided to you for each payment made.

Billing: Any personal balance over 30 days old without current payments applied against it is considered an overdue balance resulting in delinquent status of the account. To avoid assignment to a professional collection agency, all payments due should be made promptly. If genuine financial difficulties exist, please call. We are happy to arrange a personalized monthly budget plan.

We honor Hunterdon Medical Center's payment Assistance Program. The financial responsibility of the patient is determined by the level of assistance granted by Hunterdon Medical Center and our financial policies.

Patient/Print Name: _____

Patient/ Responsible Party Signature: _____

Patient/ Responsible Party name: _____Date:_____