JOHN C. SCOLAMIERO, M.D.
Medical Director
Internal Medicine

A.J. SCOLAMIERO, M.D.
Associate Medical Director
Family Practice

PATIENT REGISTRATION SHEET

MR#: _____
RAD#: _____

HOME PHONE #:
WORK PHONE #:
CELL #:
EMAIL:

PLEASE FILL OUT COMPLETELY AND SIGN

DATE:

LAST NAME	FIRST NAME	MI	SEX	SOCIAL SECURITY #:

DATE OF BIRTH	AGE	MARITAL STATUS	
		SINGLE ☐ WIDOWED ☐ SEPARATED ☐ MARRIED ☐ DIVORCED ☐	EMPLOYED ☐ STUDENT ☐ RETIRED ☐ UNEMPLOYED ☐

HOME ADDRESS	CITY	STATE	ZIP CODE

NOTIFY IN CASE OF EMERGENCY	PHONE #:	RELATIONSHIP

RACE: ☐ WHITE/CAUCASAN ☐ AFRICAN AMERICAN ☐ ASIAN ☐ NATIVE AMERICAN
☐ OTHER_____ ☐ DECLINES TO ANSWER

ETHNICITY:	PREFERRED LANGUAGE:
☐ HISPANIC/LATINO ☐ NON HISPANIC/LATINO ☐ DECLINES TO ANSWER	☐ ENGLISH ☐ SPANISH ☐ ITALIAN ☐ RUSSIAN ☐ GERMAN ☐ FRENCH ☐ OTHER_____ ☐ DECLINES TO ANSWER

PATIENT OR GUARDIAN'S SIGNATURE AUTHORIZES THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNED: _____ DATE: _____

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PATIENT INSURANCE ADVISORY
PLEASE FILL OUT COMPLETELY AND SIGN

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY	ID#:	GROUP#:	
POLICY HOLDER'S NAME	DATE OF BIRTH	SEX	PHONE #(IF DIFFERENT FROM ABOVE)
ADDRESS (IF DIFFERENT FROM ABOVE)			
RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐	EMPLOYER		
SECONDARY INSURANCE	ID#:	GROUP#:	
POLICY HOLDER'S NAME	DATE OF BIRTH	SEX	PHONE # (IF DIFFERENT FROM ABOVE)
ADDRESS (IF DIFFERENT FROM ABOVE)			
RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐	EMPLOYER		

Please be advised that due to significant changes in insurance plans you must provide this office with a current insurance card at each visit. Plans change frequently and coverage varies by plan, which is why we need to verify your insurance EACH & EVERY time you come in.

Please understand that you, the patient, are responsible for providing the office with any updated insurance information you receive that may affect your coverage. Failure to provide a valid insurance card each time you come for a visit, or if we are unable to verify your insurance coverage at the time of your visit may necessitate this office to bill you directly for all charges incurred.

I, the undersigned, agree to provide a valid and current insurance card at each visit. I understand that if my insurance information is not up to date or my coverage can't be verified that I will be responsible for the cost of all charges incurred.

_____ Date: _____
Patient's Signature

New Patient
Medical Questionnaire

Name:_____ Date:_____

Medical Problems and/or

Illnesses you have had in the past:

1. _____
2. _____
3. _____
4. _____
5. _____

Operations/Surgical Procedures:

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications:

_____
_____
_____
_____

Medicine Allergies:

_____
_____
_____
_____

Food Allergies:

_____
_____
_____
_____

Family's Medical History: Please list any known medical history

*Mother*_____ *living/deceased* *Cause of death*_____

*Father*_____ *living/deceased* *Cause of death* _____

*Brother*_____ *Sister*_____

Do you smoke? ____Yes ____No

How much?

- Less than ½ pack daily
- ½ pack daily
- 1 pack daily
- 1 ½ - 2 packs daily
- More than 2 packs daily

Do you use alcohol socially?

____Yes ____No ____None at all

MED-CARE HIPAA FORM

245 PARK AVENUE, E. RUTHERFORD, NJ 07073
150 FAIRFIELD ROAD, FAIRFIELD, NJ 07004

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PRIVACY POLICY
Your Rights With Respect to Your Personal Health Information

Under **HIPAA**, you have certain rights with respect to your personal health information. You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: (a) to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

You have the right to review our notice before signing this consent. By signing this form, you consent to our use and disclosure of protected healthcare information about you for treatment, payment and healthcare operations. You have the right to revoke consent, in writing, signed by you. However, such a revocation shall not affect disclosures we have already made in reliance on your prior consent. Med-Care provides this form to comply with the Health Insurance Portability Accountability Act of 1996 (HIPAA).

CONSENT TO RELEASE INFORMATION

By signing this form, I permit Med-Care to release any medical information to physicians involved in my care. I consent that Med-Care may call my house or other designated location and leave a message on my voice mail or in person in reference to an appointment, reminders and insurance items. In addition, Med-Care may mail to my home patient statements and medical results.

I designate the following representative(s) who the provider can communicate with on my behalf. If I do not designate anyone, the doctor will be unable to speak to anyone in my family regarding my medical condition.

NAME **RELATIONSHIP**

NAME **RELATIONSHIP**

PATIENT OR LEGAL GUARDIAN_____

(PLEASE PRINT)

PATIENT OR LEGAL GUARDIAN_____ _____

(SIGNATURE) **(DATE)**