



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.**

Signature of Patient/ Health Care Agent/ Guardian/ Relative \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(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**

PSO NJ 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 PSO NJ may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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 (List approx. Date/Year): \_\_\_\_\_

Prevnar13 (List approx. 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: \_\_\_\_\_

1<sup>st</sup> Booster (Dose #3) Brand Name and Date if given: \_\_\_\_\_

2<sup>nd</sup> Booster (Dose #4) Brand Name and Date if given: \_\_\_\_\_

**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



## 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 remainder.
- If you have a high account balance, a **payment arrangement** can be made with our office manager. This is important to avoid any account delinquency or collection agency involvement. If you have an outstanding balance in excess of 120 days and have not made a current payment, PSONJ may contact you to cancel any future appointments until a payment can be made.
- 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: \_\_\_\_\_