EMPIRE MEDICAL

www.myempiremedical.com
264 Boyden Ave. Maplewood, NJ 07040 • (973) 761-5200
5 Franklin Ave. Suite 302, Belleville, NJ 07109 • (973) 759-1221
382 W. Passaic Ave. Bloomfield, NJ 07003 • (973) 338-1900
55 Morris Ave. Springfield Township, NJ 07081 • (973) 376-0540

PATIENT REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Doctor:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Email address:

Occupation:	Employer:	Employer phone no.: ( )

Employer Address:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

Spouse's Name	Employer:	Employer phone no.: ( )

Employer Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Primary Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

"The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize EMPIRE MEDICAL ASSOCIATES, P.C. or insurance company to release any information required to process my claims. I request that payments of authorized Medicare benefits be made either tome on my behalf or to EMPIRE MEDIACL ASSOCIATES, P.C. for any services furnished to me by my physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

_____ _____

Patient/Guardian signature *Date*

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Date of Birth
Previous or referring doctor:			Date of last physical exam:		
Pharmacy:	Phone:	Address:			

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

PAST MEDICAL HISTORY

Condition/Disease	Year Diagnosed	Other(s)	Year Diagnosed
☐ Hypertension (high blood pressure)			
☐ High Cholesterol			
☐ Hypothyroidism (low thyroid)			
☐ COPD, Emphysema or Asthma			
☐ Diabetes			
☐ GERD			
☐ Depression or Anxiety			
☐ Heart Problems			
☐ Migraine			

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

Have you ever had a blood transfusion? ❑ Yes ❑ No

PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, VITAMIN AND SUPPLEMENTS

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS/FOOD/OTHER

Name the Drug/Food	Reaction You Had

DISEASE PREVENTION AND HEALTH MAINTENANCE

Please list below the most recent dates of your vaccines and health screening test

	Month/Year		Month/Year		Month/Year
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Stress Test (heart)	
		EKG			
		Annual Physical Exam			

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No

	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			Children	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		Grandmother *Maternal*		
	☐ M ☐ F		Grandfather *Maternal*		
	☐ M ☐ F		Grandmother *Paternal*		
	☐ M ☐ F		Grandfather *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

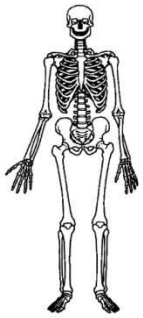
MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

PERIPHERAL ARTERIAL DISEASE (PAD) ASSESSMENT	
Have you ever been diagnosed with peripheral vascular disease or been diagnosed as having poor circulation?	☐ Yes ☐ No
Have you ever had surgery, balloon procedures or stents in our heart, kidney or belly?	☐ Yes ☐ No (if yes, date_____)
When you walk, do you experience aching, cramping or pain in your legs, thighs or buttocks	☐ Yes ☐ No
If you answered yes, when do you feel pain? ☐ After walking one block ☐ Climbing a flight of stairs ☐ After walking 100 yards Walking at increased speed	
If you answered yes, circle the area(s) of the body on the diagram below where you feel pain 	
If you have pain, does it subside with rest?	☐ Yes ☐ No
Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed?	☐ Yes ☐ No
Do you have painful sores or ulcers o n legs or feet that do not heal?	☐ Yes ☐ No
Are you legs discolored or bluish?	☐ Yes ☐ No
Check all that apply ☐ I am a current smoker ☐ I have a history of smoking ☐ I have diabetes ☐ I have a family history of diabetes ☐ I have high cholesterol ☐ I have a family history of high cholesterol ☐ I have high blood pressure/hypertension ☐ I have coronary artery disease (CAD) ☐ I have a family history of coronary artery disease ☐ I have had a stroke/mini stroke/TIA ☐ I have a family history of stroke/mini stroke/TIA	

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have acknowledged that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized representative (if applicable)

_____
Signature

EMPIRE MEDICAL ASSOCIATES, P.C. MISSED APPOINTMENT POLICY

We are glad you have chosen us to provide your medical care, but if you miss your appointments, you compromise that care. We want to remind you of our office policies regarding missed appointments.

A missed appointment is when you fail to show up for an appointment without a phone call, or cancel without at least a 24-hour notice.

A doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and that you give us the courtesy of a call when you are unable to keep your appointment. Below, our missed appointment policies are outlined.

Let's work together to provide you the best possible care you deserve.

- **Missed Appointment with Primary Care Physician or Specialist:** we will call and offer to reschedule your appointment. **You may be charged a missed appointment fee of $25**.
- **Missed appointment for a scheduled visit or procedure with a Specialist:** We'll call and offer to reschedule your appointment. **You WILL be charged a missed appointment fee of $50.**
- **Missed appointment for a scheduled nuclear stress test.** We'll call and offer to reschedule your appointment. **You WILL be charged a missed appointment fee of $150.**

Your signature below indicates that you have read, understood and accept the missed appointment policy that Empire Medical Associates, P.C. has put in place for all office location.

Please feel to discuss this policy with our office staff.

_____ _____
Signature Date

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Date of Birth

I REQUEST THAT ALL COMMUNICATIONS TO ME (BY TELEPHONE, MAIL OR OTHERWISE) BY EMPIRE MEDICAL ASSOCIATES, P.C. AND/OR ITS STAFF BE HANDLED IN THE FOLLOWING MANNER:

For written communications: Address to _____

_____

_____

For oral communications: Call _____
(telephone number)

May we leave a message?
☐ Yes
☐ No

If you would like to authorize another person(s), such as a legal guardian, for whom we may leave a message and/or contact with your medical information, please provide name, address and phone number(s). Please state that you authorize the designee. (e.g. I authorize…)

_____

_____

_____

_____

_____ _____
Patient Signature Date

For practice use only

Practice _____ Accepts _____ Denies _____

Privacy Officer Signature _____

Date _____

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PATIENT PORTAL

Please be aware that we offer a patient portal for you to communicate with our office for appointments, forms, refills on medications and requests for results.

In order to do so, please provide the office staff with a current email so we may send you a registration link.

Once you receive the registration link, the prompts will instruct you on what steps you need to take.

Please inform our office staff of any problems or questions.

Thank you!

Patient's Name _____

Date of Birth _____

Email Address _____