The following forms were given at time of check in:

_____ initials _____

date

☐ Pt Bill of Rights
☐ HIPPA Rights
☐ Medicare Questionnaire
☐ ABN (if not applicable just mark N/A) _____

Barnabas Health

Saint Barnabas Medical Center
Barnabas Health Ambulatory Care Center

200 SOUTH ORANGE AVENUE, LIVINGSTON, NJ 07039
TEL: 973 322-7700 FAX: 973-322-7397

PATIENT REGISTRATION FORM

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF SURGERY

PATIENT INFORMATION				
PATIENT NAME	DATE OF SURGERY	HOME PHONE	SOCIAL SECURITY NO.	
STREET ADDRESS	DATE OF BIRTH	WORK PHONE	MARITAL STATUS	SEX
CITY, STATE, ZIP CODE	EMERGENCY CONTACT / RELATIONSHIP TO PATIENT		PHONE	
EMPLOYER - NAME, ADDRESS, CITY, STATE, ZIP CODE			PHONE	

PRIMARY INSURED'S INFORMATION			
NAME	HOME PHONE	WORK PHONE	SOCIAL SECURITY NO.
STREET ADDRESS - CITY, STATE, ZIP CODE			
EMPLOYER - NAME, ADDRESS, CITY, STATE, ZIP CODE			DATE OF BIRTH

PATHOLOGY 800-887-3070 AND ANESTHESIA 973-660-9334 ARE BILLED SEPARATELY. PLEASE CONTACT THESE DEPARTMENTS WITH ANY QUESTIONS.

INSURANCE INFORMATION			
PRIMARY INSURANCE		SECONDARY INSURANCE	
BILLING ADDRESS		BILLING ADDRESS	
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
INSURED'S NAME	PHONE NO.	INSURED'S NAME	PHONE NO.
PATIENT'S RELATIONSHIP TO INSURED	DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED	DATE OF BIRTH
GROUP NAME	GROUP NO.	SOC. SEC. NO.	GROUP NO.
INSURED'S ID NO.	PRE-CERTIFICATION NO.	INSURED'S ID NO.	PRE-CERTIFICATION NO.
EMPLOYER NAME		EMPLOYER NAME	
EMPLOYER ADDRESS		EMPLOYER ADDRESS	
DATE/TIME OF ACCIDENT	CLAIM NO.	ADJUSTER	

I hereby certify that:

1. I am financially responsible for the patient named above and attest that the information provided is correct.
2. I authorize Barnabas Health ACC Ambulatory Surgery Center to submit claims for medical benefits to which I am entitled to insurance companies, governmental agencies and others, and authorize that such benefits be paid directly to the provider; and I authorize release of all records required to act on this request.
3. I understand that I am responsible for changes not paid by insurance, or not covered by this assignment.

_____ _____ _____

SIGNATURE OF RESPONSIBLE PARTY | DATE | RELATIONSHIP TO PATIENT

Barnabas Health

Saint Barnabas Medical Center
Barnabas Health Ambulatory Care Center

Patient Name:

Date of Birth:

Medical Record #:

ALLERGIES / ADVERSE ALLERGIC DRUG REACTIONS
(Note symptoms exhibited)

Label

Medications: _____

Other: _____

INITIAL VISIT DATE: _____

Breast Center - Medication Reconciliation Form

Current Medications from home - includes prescribed, over the counter or herbal medications, and supplements

Source of Information: ☐ Patient ☐ Other _____

(*See comments . . . as some meds may have a prolonged effect)

INITIAL VISIT: MEDICATION NAME	DOSE	FREQUENCY/ ROUTE	D/C DATE	DATE	FOLLOW UP VISITS: MEDICATION NAME	DOSE	FREQUENCY/ ROUTE	COMMENT	D/C DATE
☐ None					**After Today's Procedure:** Use acetaminophen (Tylenol) for pain if necessary. Tylenol 325mg tablets by mouth. Take 1 tablet every 4-6 hours for mild pain. Take 2 tablets every 4-6 hours for moderate pain. Do not take more than 8 tablets in 24 hours.				

_____ _____
Signature of person completing form/relationship to patient — Initial Visit Date

_____ _____
Signature of RN reviewing initial medication list — Date/Time

S - Sample (See sample book for details)
Rx - New prescription
***PE** - Prolonged effect (greater than 72 hours)
O - Prescribed by another physician
U - Unknown at this time - Pt. requested to bring in meds next visit

Copy given to patient [ ] Yes [ ] NA [ ] Refused

Original File Copy - Duplicate Patient