RWJ Center for Women's Health | RWJBarnabas HEALTH

You have an appointment at RWJ Women's Health. Please arrive 30 minutes before your appointment to make sure that all necessary paper work is in place prior to your scheduled visit.

We ask that you bring a copy of your living will if applicable, insurance cards and photo ID with you to your appointment.

We would appreciate if you could provide the following list of items to our office at least 48 hours prior to your scheduled appointment, if not please make sure you arrive 30 minutes prior to your scheduled appointment to allow for processing of packet

- ***Completed Patient Registration Packet***
- ***Previous medical records (lab reports, surgery reports, radiology reports, doctor's notes)***

Thank you,

The Staff RWJ Women's Health

RWJ CENTER FOR WOMEN'S HEALTH

Patient Account #:	Age: Gender:
Patient Name:	Date of Birth:
Address:	Social Security #:
City:	Home Phone #: Msg: □Y□N
State: Zip:	Work Phone#: Msg: □Y□N
Living Will? Y N	Cell #: Msg: □Y□N
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Refuse to Report	Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian □ White □ Other Pacific Islander □ More than 1 Race □ Refused to Report/Unreported
Language: □ English □ Spanish □ Arabic □ Chinese □ Hindu □ Other	
Religion:	Pharmacy Name:
Marital Status:	Pharmacy #:
Spouse/Partner's Name:	Email Address:

Patient Referral Information:

Referring Physician:	Phone #: Fax:
Primary Care Physician:	Phone #: Fax:

Patient's Primary Insurance Information: Referral Needed: □Y□N

Insurance Company:	ID#:
Subscriber Name:	Subscriber Date of Birth:
Group #:	Subscriber SS#:
Relationship to Patient:	Insurance Co Phone #:
Insurance Address:	City,State,Zip:

Patient's Secondary Insurance Information: Referral Needed: □Y□N

Insurance Company:	ID#:
Subscriber Name:	Subscriber Date of Birth:
Group #:	Subscriber SS#:
Relationship to Patient:	Insurance Co Phone #:
Insurance Address:	City,State,Zip:

How Did You Hear About Us: (check all that apply) «AdditField17»

□ Internet □ Advertising	□ Referred by Physician:
□ Other:	□ Referred by friend/relative:

Employment Information:

Employer's Name:	Phone #:
Address:	City,State,Zip:
Your Occupation:	

Emergency Contact Information:

Emergency Contact:	Relationship:
Home Phone #:	Cell Phone #:

HIPAA Information/Consent:

-I acknowledge receipt of the Notice of Health Information Practice: _____
(initials)

_If I am not available to receive my test results, I authorize you to release the information to: _____
(NAME OF AUTHORIZED PERSON)

-I do not wish you to report any results to anyone other than myself . _____
(True or False)

Should inaccurate or omitted insurance information be supplied causing a reduction or non-payment of benefits, the obligation of payment will be transferred to the responsible party. I hereby authorize the release of any medical information about me to my insurance company, its intermediaries or carriers, to my attorney or another physician's office. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to RWJ Women's Health. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____
Signature of patient or responsible party Date

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RWJ WOMEN'S HEALTH

New Patient Intake History

PATIENT INTAKE HISTORY

Patient Name:			
Date of Birth:	Race:	Ethnicity:	Primary Language:
Why you have come to the office today?			
Please describe your problem (location, how severe, how long has it lasted):			
What is your current pain level on a scale from 1-10 (1 being lowest, no pain; 10 being highest, severe pain)			

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

HISTORY OF ILLNESSES

Please check any illnesses <u>you</u> have had previously.

❑ Asthma	❑ Pneumonia/Lung Disease	❑ Kidney Infections/Stones
❑ Tuberculosis	❑ Fibroids	❑ STD/Chlamydia
❑ Infertility	❑ HIV/AIDS	❑ Heart Attack/Disease
❑ Diabetes	❑ High Blood Pressure	❑ Stroke
❑ Rheumatic Fever	❑ Blood Clots in Lungs or Legs	❑ Eating Disorders
❑ Autoimmune Disease (i.e., Lupus)	❑ Chickenpox	❑ Cancer
❑ Reflux/Hiatal Hernia/Ulcers	❑ Depression/Anxiety	❑ Anemia
❑ Blood Transfusions	❑ Seizures/Convulsions/Epilepsy	❑ Bowel Problems
❑ Glaucoma	❑ Cataracts	❑ Arthritis/Joint Pain/Back Problems
❑ Broken Bones	❑ Hepatitis/Yellow Jaundice/Liver Disease	❑ Thyroid Disease
❑ Gallbladder Disease	❑ Headaches	❑ Diethylstilbestrol Exposure
❑ Infertility	❑ Bleeding Disorders	❑ Other:

ALLERGIES

Are you allergic to any medications?	❑No ❑Yes; Please specify (including reaction):
Do you have any food allergies?	❑No ❑Yes, Please specify (including reaction):
Are you allergic to Latex?	❑No ❑Yes
Other Allergies (including reaction):	

FAMILY HISTORY

Please document any illnesses <u>your family</u> has had below.

Mother: ❑Living ❑Deceased; Cause:	Father: ❑Living ❑Deceased; Cause:

Siblings: Number Living: Number Deceased: Cause:			
Children: Number Living: Number Deceased: Cause:			
ILLNESS	**Which relative & age of onset**	**ILLNESS**	**Which relative & age of onset**
❑Diabetes		❑Stroke	
❑Heart Disease		❑Blood Clots in Lungs or Legs	
❑High Blood Pressure		❑High Cholesterol	
❑Osteoporosis (Weak Bones)		❑Hepatitis	
❑HIV/AIDS		❑Tuberculosis	
❑Birth Defects		❑Alcohol or Drug Problems	
❑Breast Cancer		❑Colon Cancer	
❑Ovarian Cancer		❑Uterine Cancer	
❑Mental Illness/Depression		❑Alzheimer's Disease	

SOCIAL HISTORY

What is your tobacco use/smoking status:	❑Current smoker; Packs per day: Number of years: ❑Have never smoked ❑Smoke occasionally ❑Former smoker; when did you quit:
What is your alcohol intake:	Drinks per day: Drinks per week: Type of drink:
What is your drug use (illegal/street or prescription misuse):	❑No Drug Use ❑Former Drug Use ❑Drug Use; Specify:
What is your current exercise routine:	How long: How often:
Do you have any pets/animals in your home?	❑No ❑Yes, please specify:
What is your relationship status?	❑Married ❑Living with partner ❑Single ❑Widowed ❑Divorced
Have you been sexually abused, threatened or hurt by anyone?	❑No ❑Yes

GYNECOLOGIC HISTORY

Last normal menstrual period (First day):	/ /
Age periods began:	
Length of periods (Number of days of bleeding):	
Number of days between periods:	
Any recent changes in periods?	❑No ❑Yes
Have you ever had sex?	❑No ❑Yes
Are you currently sexually active (vaginal, oral, anal)?	❑No ❑Yes
Number of sexual partners (Lifetime):	
Sexual partners are:	❑Men ❑Women ❑Both
Present methods of birth control & STD protection:	

CURRENT MEDICATIONS

List all medications you <u>currently</u> take below (including hormones, vitamins, herbs, nonprescription medications).

DRUG NAME	Dosage	Who Prescribed	DRUG NAME	Dosage	Who Prescribed

PREGNANCY/BIRTH HISTORY

	NUMBER		NUMBER		NUMBER
Pregnancies:		Abortions:		Miscarriages:	
Premature Births (<37 weeks):		Full Term Deliveries (>37 weeks):		Living Children:	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (Vaginal or Cesarean)
1					
2					
3					
4					

Any Pregnancy Complications? ❑None ❑Diabetes ❑Hypertension/High Blood Pressure ❑Preeclampsia/Toxemia ❑Other:

Any history of depression before or after pregnancy? ❑No ❑Yes; How treated:

PAST SURGICAL PROCEDURES/HOSPITALIZATIONS

PROCEDURE / REASON	DATE	HOSPITAL

HEALTH MAINTENANCE

When was your last Pap Test?	/ /	Result:
Have you ever had an abnormal Pap Test?	❑No ❑Yes	
When was your last HPV Test?	/ /	Result:
When was your last Mammogram?	/ /	Result:
When was your last DEXA Scan?	/ /	Result:

REVIEW OF SYSTEMS

Please check any symptoms you are <u>currently</u> experiencing or have experienced <u>recently</u>.

GENERAL:	❑Change in Height	❑Fatigue	❑Fever
	❑Weight Gain	❑Weight Loss	
HEAD, EYES, EARS, NOSE, THROAT:	❑Spots before Eyes	❑Vision Changes	❑Double Vision
	❑Wears glasses/contact lenses	❑ Hearing Loss	❑ Earache
	❑Ringing in Ears	❑Sinus Problems	❑Dental Problems
	❑Oral Sores	❑Sore Throat	
CARDIOVASCULAR:	❑ Chest Pain	❑ Difficulty Breathing on Exertion	❑Irregular Heart Beat
	❑Rapid Heart Rate	❑ Swelling of Legs	
RESPIRATORY:	❑Chronic Cough	❑Difficulty Breathing	❑Short of Breath
	❑Spitting up Blood	❑Wheezing	
GASTROINTESTINAL:	❑Bloody Stool	❑Constipation	❑Diarrhea
	❑Indigestion	❑Involuntary Loss of Gas or Stool	❑ Nausea
	❑Vomiting		
GENITOURINARY:	❑Abnormal Bleeding	❑Blood in Urine	❑Difficulty Emptying Bladder
	❑Frequent Urination	❑Involuntary Urine Loss	❑Painful Intercourse
	❑Painful Menstruation	❑Painful Urination	❑Premenstrual Syndrome (PMS)
	❑Urgency to Urinate	❑Vaginal Discharge	❑Urine Leakage
MUSCULOSKELETAL:	❑Joint Pain	❑Muscle Pain	❑ Muscle Weakness
SKIN:	❑Change in Wart/Mole	❑Dryness	❑Rash
	❑Sores		
BREAST:	❑Breast Pain	❑Lump(s)	❑Nipple Discharge
NEUROLOGIC:	❑Decreased Memory	❑Dizziness	❑Headaches
	❑Numbness	❑Seizures	❑Trouble Walking
PSYCHIATRIC:	❑Anxiety	❑Depression	❑ Frequent Crying
ENDOCRINE:	❑Cold Intolerance	❑Excessive Thirst	❑Hair Changes
	❑Heat Intolerance	❑ Hot Flashes	
HEMATOLOGIC/LYMPHATIC:	❑Easy Bruising	❑Enlarged Lymph Nodes (Glands)	❑Excessive Bleeding

PATIENT SIGNATURE

Signature of Patient:	
Date:	

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Please release all records to:

RWJ Center for Women's Health
1A Quakerbridge Plaza
Hamilton, New Jersey 08619
Phone: (609) 631-6899
Fax: (609) 631-6898

_____

_____

_____

I hereby authorize the release of all my medical records to RWJ Women's Health.

PATIENT NAME: _____

PATIENT ADDRESS: _____

_____

DATE OF BIRTH: _____

_____ _____

Patient/ Authorized Representative Date

Name: _____ DOB: _____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf, to Christian Hoffman, MD, Anjali Bhandarkar, MD, Gary Brickner, MD, Cary Mantell, DO, Robert Mayson, MD, and Lisa Tufankjian, DO. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

_____ _____
Medicare Beneficiary Signature Date

Beneficiary Medicare Number _____

To Determine if Medicare is a Secondary Payor (MSP)
According to Health Care Financing Administration Guidelines

If all questions below are answered "No", Medicare is the primary payor.
Please note that more than one situation may apply in determining the primary coverage ie., a working beneficiary may be involved in an auto accident.
If any of the questions below are answered "Yes", Medicare may be a secondary payor.
Our billing staff will make a determination based upon the information provided.

1) Do you or your spouse work for a company that provides you with health insurance?

   YES_____ NO_____

2) Are you entitled to Medicare because of disability or End Stage Renal Disease?

   YES_____ NO_____

3) Is the illness or injury for which you are seeking treatment the result of an automobile accident or other injury?

   YES_____ NO_____

4) Has treatment for this accident or illness been authorized by the Veterans Administration?

   YES_____ NO_____

5) Are you entitled to any benefits under the Federal Black Lung Program?

   YES_____ NO_____

I certify that this information is true and complete to the best of my knowledge.

_____ _____
Signature Date