SUMMIT MEDICAL GROUP

Patient Registration Form

MRN #: Sort ID:

Patient Name: DOB:

Provider: Date:

Address _____

Home Phone _____Cell Phone_____Work_____

Social Security Number _____Date of Birth _____

☐ Male ☐ Female E-mail Address_____

Is your visit today due to a job related injury? _____ A Motor Vehicle Accident? _____

Primary Care Physician_____Marital Status: S___ M ___ D___

How did you hear about Summit Medical Group? _____

Primary Health Insurance

Insurance Company Name _____Effective_____

Insurance Policy ID Number _____Group Number_____

Subscriber/Policy Holder _____

Subscriber's Address (If different than the above)_____

Subscriber Social Security Number _____Date of Birth_____

Patient's Relationship to Insured _____

Secondary Health Insurance

Insurance Company Name _____Effective_____

Insurance Policy ID Number _____Group Number_____

Subscriber / Policy Holder _____

Subscriber's Address (If different than the above)_____

Subscriber Social Security Number _____Date of Birth_____

Patient's Relationship to Insured _____

EMERGENCY CONTACT

Name_____

Phone_____Relationship_____

Signature_____Date_____

SUMMIT MEDICAL GROUP

DESIGNATION OF CERTAIN RELATIVES, FRIENDS, AND/OR OTHER CAREGIVERS

Patient Name: _____ **Date:** _____

MRN: _____ **Date of Birth:** _____

I agree that Summit Medical Group (SMG) may disclose certain portions of my health information to a relative, friend, and/or other caregiver because such person is involved with my health care or payment relating to my health care. In that instance, SMG will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

☐ I wish to make no designation at this time.

Signature of Patient/Parent/Guardian: _____

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of SMG's making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: _____ **DOB or Password*:** _____

Print Name: _____ **DOB or Password*:** _____

Print Name: _____ **DOB or Password*:** _____

Print Name: _____ **DOB or Password*:** _____

Print Name: _____ **DOB or Password*:** _____

***Please list the 4 digit (month & day) date of birth (DOB) of the person listed or choose a password. Please note, the person will have to give his/her DOB or password in order to receive any information.*

Signature of Patient/Parent/Guardian: _____

Please return to your SMG Physician Office or Mail to: HIMS Manager – 150 Floral Avenue, New Providence, NJ 07974

SUMMIT MEDICAL GROUP

SURGERY

PATIENT HISTORY INTAKE FORM

Name: _____ Today's Date: _____/_____/_____

Age: _____ Date of Birth: _____/_____/_____

What is the reason for today's visit? _____

_____

_____

When did the problem start? _____

What makes the problem better / worse? _____

What is the severity of pain associated with the problem? _____

What other symptoms are you experiencing with the problem? _____

Accident ? ☐ No ☐ Yes Type: ☐ Auto ☐ Work ☐ Other: _____

Referring Physician: _____ ☐ Check if none

Primary Physician: _____ ☐ Check if none

Have you had X-Rays taken (for this problem): ☐ No ☐ Yes

Medical History:

_____ Cancer	_____ Hypertension/Heart Disease	_____ Ulcers
_____ Anxiety/Depression	_____ Stroke/Vascular Disease/Blood Clots	_____ Diabetes
_____ Acute Infections	_____ Asthma/Other Breathing Problems	_____ Arthritis/Gout
_____ Bleeding Tendency	_____ Convulsions/Seizures	

Other_____

_____

When was your last colonoscopy ? _____

Have you ever had a vascular screening ? _____

Current Medications (including over the counter) :

Include Dosage & Frequency: _____

_____

_____

Allergies (medications, environmental, latex):

_____

Pharmacy Name (for temporary medications): _____

Address: _____

Phone: (_____) _____ Fax: (_____)_____

SUMMIT MEDICAL GROUP

SURGERY
PATIENT HISTORY INTAKE FORM

Past Surgical History ☐ No ☐ Yes
If yes, please list surgery & dates of surgery:

_____
_____
_____

Have you or your family ever had any problems/reactions with anesthesia? Yes ☐ No ☐

Have you or your family ever had any problems with bleeding after surgery? Yes ☐ No ☐

Gynecologic history:

Date of last menstrual period _____ History of miscarriages: _____

Family History (list any conditions that run in your family):

_____
_____
_____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____

Do you consume alcoholic beverages? ☐ No ☐ Yes
_____ (quantity) ☐ Daily ☐ Weekly ☐ Monthly

Smoking currently? ☐ No ☐ Yes _____ packs for _____ years.

Previously smoked _____ packs per day for _____ years. Quit _____ years ago.

Drug Use ☐ No ☐ Yes _____

Review of Systems:

Are you currently having or have you had problems with any of the following: *(Describe yes responses)*

CONSTITUTIONAL
Weight loss of 10lbs or more YES ☐ NO ☐ _____
Fevers / Chills / Night sweats YES ☐ NO ☐ _____

SUMMIT MEDICAL GROUP

SURGERY

PATIENT HISTORY INTAKE FORM

Review of Systems:

Are you currently having or have you had problems with any of the following: *(Describe yes responses)*

CARDIAC

High Blood Pressure	YES ☐	NO ☐	_____
Heart Disease	YES ☐	NO ☐	_____
Heart Murmur	YES ☐	NO ☐	_____
Palpitations	YES ☐	NO ☐	_____

RESPIRATORY

Shortness of breath	YES ☐	NO ☐	_____
Asthma / Pneumonia	YES ☐	NO ☐	_____

GENITOURINARY

Urinary/ Bladder Infections	YES ☐	NO ☐	_____
Urinary Frequency	YES ☐	NO ☐	_____

NEURO

Fainting Spells / Seizures	YES ☐	NO ☐	_____

GASTROINTESTINAL

Constipation / Diarrhea	YES ☐	NO ☐	_____
Blood in Stool	YES ☐	NO ☐	_____
Nausea / Vomiting	YES ☐	NO ☐	_____

SKIN

Problems with Scarring	YES ☐	NO ☐	_____
Skin Changes	YES ☐	NO ☐	_____

VASCULAR

Pain in calves when walking	YES ☐	NO ☐	_____
Blood clots	YES ☐	NO ☐	_____

PSYCHIATRIC

Anxiety / Depression	YES ☐	NO ☐	_____

Vital Signs: (Office Use Only)

Height: _____ Weight: _____ Blood Pressure: _____

BMI_____

Patient Signature: _____ **Date:** _____/_____/_____

Physician's Signature: _____ **Date:** _____/_____/_____

Summit Medical Group

MEDICARE ACKNOWLEDGEMENT:

I request that payment of authorized Medicare benefits be made either to me or to the Summit Medical Group or any of its individual physician members for any services furnished to me by Summit Medical Group or any of its individual physician providers. I authorize any holder of medical information about me to release to the Health Financing Administration and its agents any information needed to determine these or the benefits payable for related services._____**Initials**

COMMERCIAL INSURANCE ACKNOWLEDGEMENT:

I request that payment of authorized Health Insurance benefits be made either to me or to the Summit Medical Group or any of its individual physician members for any services furnished to me by Summit Medical Group or any of its individual physician providers._____**Initials**

PATIENT ACKNOWLEDGEMENT:

I attest that all information provided to Summit Medical Group is accurate. If any information changes, I will inform Summit Medical Group._____**Initials**

I authorize Summit Medical Group to release all medical information necessary for processing insurance claims to the insurers on file. I agree these provisions will be in effect until otherwise revoked by me._____ **Initials**

MOTOR VEHICLE INSURANCE ASSIGNMENT OF BENEFITS:

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me. This specifically includes filing arbitration/litigation in your name on my behalf against the **PIP carrier/health care carrier.** I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the “benefit denial appeals process” as set forth in the NJ Administrative Code. _____ **Initials**

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other healthcare provider, including hospitals, diagnostic centers, etc. I specifically authorize such healthcare providers to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition. _____ **Initials**

_____
Patient Name/Account Number

_____ _____
Signature of Patient, Parent, or Guardian Date

Name: _____ Date of Birth: _____ Date: _____

Summit Medical Group is participating in the U.S. Department of Health and Human Services' "Meaningful Use" program in order to provide better patient care. This program will lead to improved electronic communications and a more complete medical record for our patients. As part of this program, we are required to collect patient information such as race, ethnicity and primary language. If you prefer not to share this information, please feel free to choose the option "I Prefer Not to Report".

Please choose one from each section.

Race*:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Unknown or Other
- ☐ I Prefer Not to Report

Ethnicity*:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ I Prefer Not to Report

Primary Language:

- ☐ English
- ☐ Spanish
- ☐ Portuguese
- ☐ Polish
- ☐ French
- ☐ German
- ☐ Italian
- ☐ Other Language
- ☐ I Prefer Not to Report

**The choices of Race and Ethnicity are consistent with choices used in US Census surveys. See page 2 for the US government's definitions of Race and Ethnicity.*

Summit Medical Group will soon offer our patients online access to certain portions of their personal health records through a "patient portal". In addition, we will also soon provide a secure, HIPAA/HITECH compliant, electronic means for communicating with your physician and health care providers. If you are interested in participating, please provide us with your email address so we may alert you when this new patient portal is available. Your email address will not be shared with any entity outside the Summit Medical Group. There is no charge for such participation and participation is entirely optional.

Email address: _____

Definitions of Race and Ethnicity as defined by the US Government:

American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment

Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."