IMPACT MEDICAL
Allergy, Asthma & Immunology

PRIMARY OFFICE
44 Route 23 North, Suite 6
Riverdale, NJ 07457
P: 973-248-9199 | F: 973-248-9299

Patient Responsibility Form

We would like to take this opportunity to welcome you to our practice. Please take this opportunity to read and sign this form to acknowledge your understanding of our patient financial policies.

INSURANCE: We are participating with most plans. We will file all of these insurance claims on your behalf. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for paying in full. Not all insurance plans cover all services. In the event your insurance plan determines a procedure to be a noncovered benefit, you will be responsible for charges incurred. Payment is due upon receipt of a statement from our office. Late fees will be incurred for balances that are beyond 30 days due.

COPAYMENTS, DEDUCTIBLES AND COINSURANCE: You are required to pay any copay, deductible, or coinsurance amount in accordance with your insurance plan. Please be prepared to pay your copay at the time of service. If you are unable to pay your copay, we will be happy to reschedule your appointment. We accept cash, check, and credit cards.

MINOR CHILDREN: Any changes incurred on a minor child's account will be billed to the parent or guardian of the child. As such, we will need demographic information on the parent/guardian at the time of the child's visit. In the case of divorced parents, the parent bringing the child to his/her appointment will be responsible for any copays or balances even if that parent is not the primary subscriber to the child's insurance policy. It is our office policy not to treat minor children unless they are accompanied by a parent or guardian.

RETURNED CHECKS: Will incur a $25 service charge.

REFERRALS: Your insurance may require a referral to be issued prior to the appointment. You must call your insurance to confirm whether or not you need a referral. Obtaining the referral is your responsibility. If you do not have a referral at the time of the visit, you will have the option to reschedule the appointment, or keep the appointment and be responsible for the payment. It is your responsibility to make a note of your referral's expiration date and number of visits.

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of the HIPAA Privacy Practice for Impact Medical - Allergy, Asthma & Immunology. We will not disclose any health information to another person, but may need to advise other family members of any fiscal responsibility due from a mutual guarantor.

RESPONSIBILITY OF PAYMENT: I have read and understand the above policies. I agree to accept full financial responsibility. I authorize Impact Medical - Allergy, Asthma & Immunology to release medical information necessary for claims payments.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

Please print name of patient: _____

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Patient Registration Form

PATIENT INFORMATION

Patient First Name (full legal name): _____ Middle Name: _____

Last Name: _____ Date of Birth: _____ Gender: M ☐ F ☐

Social Security Number: _____- _____-_____ Marital Status: _____

Patient's Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Do we have permission to leave messages regarding protected health information? YES ☐ NO ☐

If yes, with whom may we do so? _____

Referred By: _____ Primary Care Physician: _____

Primary Care Physician Phone: _____ Pharmacy Phone: _____

Pharmacy Address: _____

PATIENT EMPLOYER / SCHOOL INFORMATION

Employer / School: _____ Occupation: _____ Employer / School Phone: _____

Employer / School Address: _____ City: _____

State: _____ Zip Code: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Emergency Contact Phone: _____

Relation to Patient: _____

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BILLING AND INSURANCE (insurance card not required, must be completed)

PRIMARY HEALTH INSURANCE

Insurance Company: _____ Plan: _____

Policy Holder's Name (full legal name): _____

Relation to Patient: _____ Policy Holder's Phone Number: _____

Policy Holder's Address: _____ City: _____ State: _____

Zip Code: _____ Policy Holder's Social Security #: _____- _____-_____

Policy Holder's Date of Birth: _____ Policy Holder's Gender: M ☐ F ☐

SECONDARY HEALTH INSURANCE

Insurance Company: _____ Plan: _____

Policy Holder's Name (full legal name): _____

Relation to Patient: _____ Policy Holder's Phone Number: _____

Policy Holder's Address: _____ City: _____ State: _____

Zip Code: _____ Policy Holder's Social Security #: _____- _____-_____

Policy Holder's Date of Birth: _____ Policy Holder's Gender: M ☐ F ☐

_____ _____

Signature of Patient or Legal Guardian (if patient is <18 years old) Date

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Name: _____ Date of Birth: _____ Date of Appointment: _____

REASON FOR VISIT

What brings you to the office today?: _____

_____

Date symptoms started: _____ Have you lost any days from work or school?: YES ☐ NO ☐

PAST MEDICAL HISTORY

Have you ever had any of the following?

- ☐ Acne
- ☐ AIDS / HIV
- ☐ Anaphylaxis
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disorder
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Depression
- ☐ Ear Problems
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Epilepsy
- ☐ Gallstones
- ☐ GERD (reflux/heartburn)
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis B
- ☐ Hepititis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Kidney Stones
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Nasal Polyps
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Sinusitis
- ☐ Skin Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Problem
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Sexually Transmitted Infection
- ☐ Other: _____

_____

_____

_____

HOSPITALIZATIONS & SURGERIES

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

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MEDICATIONS

What medications are you currently taking?

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

ALLERGIES & ASTHMA HISTORY

Are your symptoms worse in certain seasons of the year? ☐ Spring ☐ Summer ☐ Fall ☐ Winter

Are your symptoms worse: ☐ At home ☐ At work ☐ On vacation ☐ Other: _____

Have you ever had an allergy skin test? ☐ Yes ☐ No If yes, when: _____

Have you ever had an allergy blood test? ☐ Yes ☐ No If yes, when: _____

Have you ever had allergy shots? ☐ Yes ☐ No If yes, when: _____

Have you ever had hives/rashes/any kind of generalized reaction to an allergy shot?

☐ Yes ☐ No If yes, when: _____

Have you ever had wheezing or asthma as a reaction to an allergy shot?

☐ Yes ☐ No If yes, when: _____

Have you ever gone to the emergency room for asthma treatment?

☐ Yes ☐ No If yes, when: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

MEDICAL:

- ☐ ACE Inhibitors
- ☐ Adhesive Tape
- ☐ Anesthetics
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine (including contrast dye)
- ☐ Latex
- ☐ NSAIDs (Ibuprofen, Advil)
- ☐ Penicillin
- ☐ Seizure Medicines
- ☐ Sulfa

FOODS:

- ☐ Dairy
- ☐ Eggs
- ☐ Nuts
- ☐ Shellfish
- ☐ Soy
- ☐ Wheat

ENVIRONMENT:

- ☐ Bee Stings
- ☐ Cats
- ☐ Cleaning Agents
- ☐ Dogs
- ☐ Dust
- ☐ Grass Pollen
- ☐ Mold
- ☐ Other Insect Stings
- ☐ Perfumes
- ☐ Strong Odors
- ☐ Tree Pollen
- ☐ Weed Pollen

Details / Reactions: _____

_____

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Name: _____ Date of Birth: _____ Date of Appointment: _____

Current Height: _____ Current Weight: _____

HEALTH MAINTENANCE

Have you had a colonoscopy? ☐ Yes ☐ No If yes, when was your last one: _____

If no, why not? _____

Have you had a mammogram? ☐ Yes ☐ No ☐ N/A If yes, when was your last one: _____

If no, why not? _____

IMMUNIZATIONS

Did you receive a flu shot this year? ☐ Yes ☐ No If yes, when? _____

If yes, where? _____

If no, why did you not receive the flu shot? _____

Have you received a pneumonia vaccination? (answer if >65 years of age) ☐ Yes ☐ No ☐ N/A

If yes, when? _____ If yes, where? _____

If no, why not? _____

SOCIAL HISTORY

Are you a current smoker? ☐ Yes ☐ No If yes, how much? _____

If yes, how long have you been smoking? _____ If no, are you a former smoker? ☐ Yes ☐ No

If yes, how much did you smoke and for how long? _____

When did you quit? _____ Are there smokers in the home? ☐ Yes ☐ No