



44 Route 23 North, Suite 6
Riverdale, NJ 07457

140 Route 17 North, Suite 204
Paramus, NJ 07652

261 James Street, Suite 1D
Morristown NJ, 07960

Patient Registration Form

Patient Information

Patient's First Name (full legal name)		Middle Name	Last Name	
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Marital Status	
Patient's Address		City	State	Zip Code
Home Phone	Cell Phone	Email Address		
Do we have your permission to leave messages regarding protected health information? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, with which may we do so? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		
If over 18, Do we have permission to discuss any medical/lab information with anyone else? (Spouse/Parent/Guardian) <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, with who may we do so?		
Referred by	Primary Care Physician	Primary Care Physician Phone		
Pharmacy	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 Holders Birthdate	Policy Holder's Gender <input type="checkbox"/> M <input type="checkbox"/> 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 Holders Birthdate	Policy Holder's Gender <input type="checkbox"/> M <input type="checkbox"/> F		

Signature of patient or legal guardian (if patient < 18 years old)

Date



44 Route 23 North, Suite 6
Riverdale, NJ 07457
(973) 248-9199

140 Route 17 North, Suite 204
Paramus, NJ 07652
(201) 523-9797

261 James St. Suite 1D
Morristown, NJ 07960
973-267-3646

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 payment 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.

Co-payments, deductibles and co-insurance: You are required to pay any co-pay, deductible, or co-insurance amount in accordance with your insurance plan. Please be prepared to pay your co-pay at the time of service. If you are unable to pay your co-pay, we will be happy to reschedule your appointment. We accept cash, check, and credit cards.

Minor children: Any charges 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 co-pays 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 Jeffrey Weiss, MD, PA 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 for payment: I have read and understand the above policies. I agree to accept full financial responsibility. I authorize Jeffrey Weiss, MD, PA to release medical information necessary for claims payments.

Signature of Patient (or Guarantor, if applicable)

Date

Please print name of patient: _____

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

Hospitalizations & Surgeries

Reason	Date
Reason	Date
Reason	Date

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 Winter Fall
- Are your symptoms worse:
 At home At work On vacation Other: _____
- Have you ever had an allergy skin test?
 Yes No When? _____
- Have you ever had an allergy blood test?
 Yes No When? _____
- Have you ever had an allergy shots?
 Yes No When? _____
- Have you ever had hives/rashes/any kind of generalized reaction to an allergy shot?
 Yes No When? _____
- Have you ever had wheezing or asthma as a reaction to an allergy shot?
 Yes No When? _____
- Have you gone to the emergency room for asthma treatment?
 Yes No When? _____

Are you allergic to any of the following?

Medical:

- | | |
|--|--|
| <input type="checkbox"/> ACE Inhibitors | <input type="checkbox"/> Iodine (including contrast dye) |
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> NSAIDs (Ibuprofen, Advil) |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Seizure Medicines |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other |

Food:

- | | | |
|--------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Nuts | <input type="checkbox"/> Soy |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Wheat |

Environment:

- | | |
|--|--|
| <input type="checkbox"/> Bee Stings | <input type="checkbox"/> Mold |
| <input type="checkbox"/> Cats | <input type="checkbox"/> Other insect stings |
| <input type="checkbox"/> Cleaning Agents | <input type="checkbox"/> Perfumes |
| <input type="checkbox"/> Dogs | <input type="checkbox"/> Strong Odors |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Tree Pollen |
| <input type="checkbox"/> Grass Pollen | <input type="checkbox"/> Weed Pollen |

Details/Reactions:

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 colonoscopy?

If no, why not? _____

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

If no, why not? _____

If you are a **diabetic**, when was your most recent A1C check or retinal examination?

Date of A1C: _____ Date of Retinal exam: _____

Date of last pap smear: _____ Not applicable

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 Not applicable

If yes, when? _____

If yes, where? _____

If no, why not? _____

Social History: _____

Are you a current smoker? Yes No

If yes, how much do you smoke? _____

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

Patients who are 65 years of age or older: _____

Have you experienced any falls withing the last 3 months?

Yes No

Do you have a secondary diagnosis that could make you more prone to falling (examples include but are not limited to Parkinson's Disease, Alzheimer's, etc.)? Yes No

Do you use any ambulatory aids? Yes No

If so, what kind of aid do you use: Crutch Cane

Walker Furniture

Do you have an IV or Heparin lock? Yes No

How would you describe your gait (ability to walk):

Normal Weak Impaired

How would you describe your mental status:

Oriented to Own Ability

Forgets limitations

Permission to Discuss Protected Health Information

Patient Name: _____ Date of Birth: _____

I give permission to Impact Medical to discuss the following medical and billing information about me:

- Medical information, including my symptoms, diagnosis, medications, and treatment plan. This may include sensitive information.
- Lab/test results
- Billing and payment information
- Scheduling/appointment information

Impact Medical has my permission to discuss the above information with:

Name	Phone	Relationship to patient

I understand that I may cancel or change this permission at any time by completing a new permission form, however cancelling it will not affect any information that has already been released. This document replaces any previously completed permission form and will remain in effect until we receive another form to replace or cancel it.

I decline permission to discuss my medical information. We will continue to protect your private health information.

Signature of patient/legal guardian

Date

Relationship to patient

If authorized representative, please provide copies of supporting legal documentation.