MDPartners
ENGLEWOOD HOSPITAL AND MEDICAL CENTER

# Patient Information Form

TODAYS DATE / /

LAST NAME | MI | FIRST NAME | GENDER ☐ Male ☐ Female ☐ Transgender ☐ Other

ADDRESS | CITY | STATE | ZIP CODE

MARITAL STATUS ☐ Married ☐ Divorced ☐ Single ☐ Widowed | DATE OF BIRTH / / | EMAIL | SSN # - -

HOME PHONE ( ) | CELL PHONE ( ) | WORK PHONE ( )

May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

Are you part of the Bloodless Medicine Program? ☐ YES ☐ NO

Do you have a Living Will/Advance Directive? ☐ YES ☐ NO

RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ White

ETHNICITY ☐ Hispanic or Latin ☐ Non Hispanic or Latin ☐ Prefer not to answer

PRIMARY LANGUAGE ☐ Chinese ☐ English ☐ Farsi ☐ French ☐ Greek ☐ Hindi ☐ Indian ☐ Italian ☐ Japanese ☐ Korean ☐ Russian ☐ Spanish ☐ Russian ☐ Other

DO YOU NEED A TRANSLATOR? ☐ YES ☐ NO

PHARMACY NAME | PHONE ( )

PHARMACY ADDRESS | CITY | STATE | ZIP CODE

EMERGENCY CONTACT #1 | RELATIONSHIP | EMERGENCY CONTACT PHONE ( )

EMERGENCY CONTACT #2 | RELATIONSHIP | EMERGENCY CONTACT PHONE ( )

*Which provider do you see to meet most of your healthcare needs?*

PRIMARY CARE PROVIDER | PHONE ( )

PRIMARY CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

REFERRING CARE PROVIDER | PHONE ( )

REFERRING CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

OTHER CARE PROVIDER | PHONE ( )

OTHER CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

OTHER CARE PROVIDER | PHONE ( )

OTHER CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

*(continued on next side)*

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## EMPLOYMENT INFORMATION

| EMPLOYER NAME | | | | OCCUPATION/POSITION |
|---|---|---|---|---|
| EMPLOYMENT STATUS | ☐ Employed Full-time | ☐ Self-employed | ☐ On active military duty | ☐ Other |
| | ☐ Employed Part-Time | ☐ Retired | ☐ Reserves | |

## INSURANCE/PAYMENT INFORMATION

PRIMARY INSURANCE *Which insurance should be billed first?*

| SUBSCRIBER NAME | | | IN WHOSE NAME IS YOUR HEALTH INSURANCE POLICY? |
|---|---|---|---|
| SUBSCRIBER SSN # - - | SUBSCRIBER DATE OF BIRTH / / | | RELATIONSHIP TO SUBSCRIBER |

| SUBSCRIBER EMPLOYER | | | |
|---|---|---|---|
| SUBSCRIBER EMPLOYER ADDRESS | CITY | STATE | ZIP CODE |
| SUBSCRIBER GENDER ☐ Male ☐ Transgender ☐ Female ☐ Other | | | |

| PRIMARY INSURANCE COMPANY | POLICY # | GROUP # | |
|---|---|---|---|
| INSURANCE COMPANY ADDRES | CITY | STATE | ZIP CODE |
| EMERGENCY CONTACT PHONE # ( ) | | | |

ADDITIONAL INSURANCE *Which insurance should be billed second? This may not apply to you.*

| SUBSCRIBER NAME | | | IN WHOSE NAME IS YOUR HEALTH INSURANCE POLICY? |
|---|---|---|---|
| SUBSCRIBER SSN # - - | SUBSCRIBER DATE OF BIRTH / / | | RELATIONSHIP TO SUBSCRIBER |
| SUBSCRIBER EMPLOYER | | | |
| SUBSCRIBER EMPLOYER ADDRESS | CITY | STATE | ZIP CODE |
| SUBSCRIBER GENDER ☐ Male ☐ Transgender ☐ Female ☐ Other | | | |
| OTHER INSURANCE COMPANY | POLICY # | GROUP # | |

## ACKNOWLEDGEMENT/AUTHORIZATION

I CERTIFY THAT ALL INFORMATION I PROVIDED ABOVE IS ACCURATE AND TRUE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR ANY SERVICES FURNISHED TO ME BY THIS PHYSICIAN GROUP. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I AUTHORIZE THE RELEASE OF MY INFORMATION CONCERNING MY HEALTHCARE TO MY INSURANCE COMPANY FOR THE PURPOSE OF REVIEWING AND PROCESSING MEDICAL CLAIMS FOR PAYMENT.

| SIGNATURE | RELATIONSHIP TO PATIENT | DATE |
|---|---|---|
| | | / / |

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## DESIGNATION OF RELATIVES, FRIENDS, AND CAREGIVERS TO RECEIVE NECESSARY TREATMENT-RELATED INFORMATION

**Patient Name:** _____ **Date:** _____

**Patient DOB:** _____

I agree that MD Partners may disclose certain portions of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care.

MD Partners will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

**Signature of Patient/Guardian:** _____ **Date:** _____

☐ I choose not to designate any individual at this time.

☐ I designate the following contacts listed below as persons involved with my health care or payment relating to my health care for MD Partners to make the limited disclosures described above.

I understand that I am not required to list anyone, and can change this list at any time in writing.

**Contact Name:** _____ **Contact's DOB (required):** _____

**Relationship:** _____

**Contact Name:** _____ **Contact's DOB (required):** _____

**Relationship:** _____

**Contact Name:** _____ **Contact's DOB (required):** _____

**Relationship:** _____

# Bergen Medical Alliance – Member of MD Partners of EHMC

Dear Patient:

We have exciting news regarding your health care!

As we continue in our efforts to provide you, our patients, with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are only aware of, but also involved in the maintenance and improvements of your health.

To that end, we are proud to announce that **Bergen Medical Alliance and MD Partners** now offers you the opportunity to use the power of the web to track all aspects of your health through our office. The **MD Partners Patient Portal** enables our patients to communicate with our practice easily, safely and securely over the Internet.

The Portal is a secure and convenient place to manage your health records and those of your family members as well. Here are just some of the many features that we think you will find useful:

Medical History:
View your medical history (or that of your family members). Medical History includes your Problem List, Allergies, Immunization Records, Lab/Imaging/Procedure Results, and Medication List.

Appointments
Receive appointments confirmation/reminder notifications.

Lab Reports
View the results of labs, imaging studies, & procedures once your healthcare provider has reviewed them.

Printing:
You can print out any information in the portal and bring it to any of the other doctors that you see outside of the MD Partners network.

Frequently Asked Questions:

1. MD Partners does not sell or share e-mail addresses with anyone. You will not receive spam emails.
2. The website is totally secure and only accessible by the user.
3. You will be able to easily access your health records, appointments and lab results.
4. Not only can you access your health information, but in the future we will use the portal to end out health notifications, such as flu shots and special features, other new features will be added over the year.
5. If you don't have an e-mail address, provide an email of a family member or caregiver you trust to access your health information.
6. You can update your demographics, insurance, and pharmacy information on the portal and save time at your next appointment.

To have access, please provide the office with an e-mail address so that we can web-enable your health information, your user name and temporary passwords will be waiting for you when you get home!

Email Address:_____ Patient Name: _____
Print Clearly Print Clearly

I decline to provide or do not have an email: please check here_____

Patient Signature:_____ Date:_____

Please return this form to the Front Desk before leaving.

# MEDICAL HISTORY DATE / /

PATIENT NAME_____ AGE_____ BIRTHDAY_____

OCCUPATION_____ ___SINGLE__MARRIED__DIVORCED__WIDOWED__SEPARATED

IF MARRIED, SPOUSE' NAME _____

CHILDREN'S NAME AND AGES _____

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES ____YES ____NO
(IF YES, PLEASE LIST NAME OF MEDICINE OR SUBSTANCES AND TYPE OF REACTION)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS
PLEASE CIRCLE IF YOU HAVE HAD PROBLEMS WITH OR ARE PRESENTLY COMPLAINING OF ANY OF THE FOLLOWING:

| | | | |
|---|---|---|---|
| 1. HIGH BLOOD PRESSURE | 2. DIABETES | 3. CANCER | 4. HEART DISEASE |
| 5. CHEST PAIN/CHEST TIGHTNESS | 6. SHORTNESS OF BREATH | 7. SWOLLEN ANKLES | 8. PALPITATIONS |
| 9. LIGHTHEADEDNESS | 10. FREQUENT URINATION | 11. RHEUMATIC FEVER | 12. ASTHMA |
| 13. BRONCHITIS | 14. PNEUMONIA | 15. PERSISTENT COUGH | 16. T.B. |
| 17. HAY FEVER | 18. ABDOMINAL DISCOMFORT | 19. INDIGESTION | 20. NAUSEA |
| 21. VOMITING | 22. CONSTIPATION | 23. DIARRHEA | 24. ULCERS |
| 25. BLOOD IN STOOL | 26. CHANGE IN BOWEL HABITS | 27. HEMORRHOIDS | 28. COLITIS |
| 29. UNEXPLAINED WIEGHT GAIN/LOSS | 30. GALL BLADDER DISEASE | 31. THYROID DISEASE | 32. HEADACHE |
| 33. HEAD OR NECK RADIATION | 34. KIDNEY DISEASES | 35. KIDNEY STONES | 36. ARTHRITIS |
| 37. DIFFICULTY URINATING | 38. LOW BACK PROBLEMS | 39. SKIN DISEASES | 40. GOUT |
| 41. BLOOD DISORDERS | 42. VENEREAL DISEASES | 43. DEPRESSION | 44. ANXIETY |
| 45. ANEMIA | 46. ALCHOL ABUSE | 47. DRUG ABUSE | 48. SMOKING |
| 49. SNORING | 50. RESTLESS LEG | 51. _____ | 52. _____ |

_____

_____

_____

_____

GYNECOLOGIC AND OBSTETRIC HISTORY

AGE AT ONSET OF PERIODS _____ FREQUENCY_____ LENGTH OF PERIOD_____

PREGNANCIES _____ BIRTHS_____ MISCARRIAGES _____

PROLONGED OR ABNORMAL BLEEDING ____NO ____YES (PLEASE DESCRIBE)_____

LEAKAGE OF URINE ____NO ____YES (PLEASE DESCRIBE) _____

PELVIC PAIN ____NO ____YES (PLEASE DESCRIBE) _____

ABNORMAL DISCHARGE ____NO ____YES (PLEASE DESCRIBE) _____

HISTORY OF ABNORMAL PAP SMEAR ____NO ____YES (PLEASE DESCRIBE) _____

MEDICATIONS (PRESCRIPTIONS, OVER-THE-COUNTER, VITAMINS, ETC.)

| DRUG NAME | DOSE | DRUG NAME | DOSE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PATIENT NAME _____ DATE / /

PLEASE LIST AND SUPPLY THE DATES OF:

OPERATIONS:

_____ _____ _____

_____ _____ _____

HOSPITALIZATIONS OTHER THAN FOR SURGERY:

_____ _____ _____

_____ _____ _____

IMMUNIZATION HISTORY - HAVE YOU HAD:

| | | | |
|---|---|---|---|
| HEPATITIS B? | ___NO ____YES WHEN? _____ | PNEUMOVAX? | ___NO ____YES WHEN? _____ |
| FLU? | ___NO ____YES WHEN? _____ | TETANUS? | ___NO ____YES WHEN? _____ |
| MMR? | ___NO ____YES WHEN? _____ | LYME? | ___NO ____YES WHEN? _____ |
| OTHER? | ___NO ____YES WHEN? _____ | OTHER? | ___NO ____YES WHEN? _____ |

FAMILY HISTORY

HAS ANY MEMBER OF YOUR FAMILY (INCLUDING PARENTS, GRANDPARENTS AND SIBLINGS) EVER HAD THE FOLLOWING?

| ILLNESS | WHICH FAMILY MEMBER? | AGE WHEN DIAGNOSED |
|---|---|---|
| CANCER (DESCRIBE TYPE) | | |
| HYPERTENSION (high blood pressure) | | |
| HEART DISEASE | | |
| DIABETES | | |
| STROKES | | |
| MENTAL DISEASE | | |
| DRUG ADDICTION | | |
| ALCOHOL ADDICTION | | |
| GLAUCOMA | | |
| BLEEDING DISEASES | | |
| OTHER _____ | | |
| OTHER _____ | | |
| OTHER _____ | | |

PREVENTION

| | | | |
|---|---|---|---|
| DO YOU WEAR SEAT BELTS? | ____NO | ____YES | IF NO, WHY NOT? _____ |
| DO YOU WEAR A BIKE HELMET? | ____NO | ____YES | ___N/A IF NO, WHY NOT? _____ |
| DO YOU SMOKE? | ____NO | ____YES | IF YES, HOW MANY PACKS/DAILY? _____ |
| DO YOU DRINK ALCOHOLIC BEVERAGES? | ____NO | ____YES | IF YES, HOW MUCH PER WEEK? _____ |
| DO YOU DRINK COFFEE? | ____NO | ____YES | IF YES, HOW MANY CUPS/DAY? _____ |
| DO YOU DRINK TEA? | ____NO | ____YES | IF YES, HOW MANY CUPS/DAY? _____ |
| DO YOU USE DRUGS? | ____NO | ____YES | IF YES, EXPLAIN: _____ |
| HAVE YOU EVER ENGAGED IN ANY ACTIVITY, WHICH HAS PUT YOU AT RISK OF GETTING AIDS? | ____NO | ____YES | IF YES, EXPLAIN: _____ |
| DO YOU WISH TO HAVE AN AIDS TEST? | ____NO | ____YES | IF YES, PLEASE DISCUSS WITH PHYSICIAN. |
| HAVE YOU EVER WORKED WITH CHEMICALS, PAINTS, ASBESTOS, OR OTHER HAZARDOUS MATERIAL? | ____NO | ____YES | IF YES, EXPLAIN: _____ |
| DO YOU HAVE A LIVING WILL? | ____NO | ____YES | |
| DO YOU HAVE A DONOR CARD? | ____NO | ____YES | |
| DO YOU USE BIRTH CONTROL? | ____NO | ____YES | IF YES, METHOD: _____ |

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# CONSENT FOR TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

1. **CONSENT FOR TREATMENT**
   The undersigned consents to any x-rays, laboratory or other medical procedures or examination rendered to me under the general and specific instructions of my physician(s). I acknowledge that no guarantees have been made to me as to the result of treatment/ examination in MDPartners. I also consent to the testing of my blood for Human immunodeficiency Viruses (HIV) and/or other blood borne pathogens, in the event that any individual at an MDPartners practice is accidentally exposed to my blood or body fluids, or my physician believes such testing is medically indicated. Results of such testing will be reported to me, noted on my medical record and reported to the State Department of Health as required by law.
2. **RELEASE OF INFORMATION**
   MDPartners is hereby authorized to release any/all of my medical records to the person(s) liable for my financial obligations resulting from services and to use data from my medical record for quality, epidemiology and education studies to which no identifying information will be made public. I authorize MDPartners to download my historical medication information from Sure Scripts.
3. **ASSIGNMENT OF INSURANCE BENEFITS**
   In the event the patient is entitled to physician benefits of any type arising out of any policy of insurance coverage from the patient or any other party liable for the patient, said benefits are hereby assigned to MDPartners and/or treating physician. In the event the patient's insurer denies medical benefits, coverage, or payment, consent is hereby authorized to allow MDPartners and/or treating physician to appeal such decisions on the patient's behalf.
4. **MEDICARE BENEFITS (IF APPLICABLE)**
   I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I assign the benefits payable for services to MDPartners or the physician furnishing the services and authorize MDPartners or the treating physician to submit a claim to Medicare for payment.
5. **MEDICAID**
   I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for practice services to MDPartners and/or treating physician. I authorize MDPartners or the physician to submit a claim to Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.
6. **OTHER PHYSICIAN SERVICES (OUTSIDE OF OUR PRACTICE)**
   In the event the patient is entitled to benefits of any type arising out of any policy of insurance covering the patient, that said benefits are also hereby assigned to any other physicians (outside of our practice) providing services to you at our request. I understand that it is the responsibility of the patient to obtain information from his/her insurance company to determine if the above mentioned physicians are participating in the patient's insurance plan. Participation by MDPartners in any given insurance plan does not indicate participation by the other physicians outside of this Practice. I understand that I am responsible to the other physicians' practices for any charges not covered by my insurance plan.
7. **FINANCIAL AGREEMENT**
   I agree, whether signing as agent or patient, that in consideration of the services rendered to the patient, I am hereby individually obligated to make payment to MDPartners in accordance with the regular rates and terms of MDPartners. I understand that I am responsible to MDPartners for any amounts billed to and not covered by any insurance carrier(s), including any amounts denied by the insurance carrier for no pre-certification or referral. Should the account be referred for collection after a default, I agree to pay costs of collection, including reasonable attorney's fee. All delinquent accounts bear interest at legal rates.

The undersigned certifies that he/she has read and understands the foregoing, receiving a copy thereof and as a patient or the patient's agent, authorized to execute the above, accepts its terms.

_____ _____ _____

Patient Signature/Authorized Agent | Date | Print Name Patient Signature/Authorized Agent

I acknowledge that I have been provided with a copy of MDPartners Privacy Notice

_____ _____

Patient Signature/Authorized Agent | Date

# MD Partners of Englewood Hospital Medical Center
# Patient Health Questionnaire

Name: _____ Date: _____

HAVE YOU RECEIVED ANY OF THE FOLLOWING?

1. FLU VACCINE WITHIN THE PAST YEAR? YES_____ NO_____ REFUSED_____

   LOCATION_____

2. PNEUMONIA VACCINE? YES_____ NO_____ REFUSED_____

   PNEUMONIA 23_____ OR PREVNAR 13____LOCATION:_____

3. HAVE YOU HAD A MAMMOGRAM WITHIN THE PAST 2 YEARS? **(AGES 40-74)**

   YES_____ NO_____ REFUSED____MASTECTOMY_____LOCATION_____

4. HAVE YOU HAD A BONE DENSITY? **(AGES 67-85) WOMEN ONLY**

   YES_____ NO_____ LOCATION_____

5. HAVE YOU HAD A COLONOSCOPY WITHIN THE PAST 9 YEARS? **(AGES 50-75)**

   YES_____ NO_____ REFUSED_____LOCATION_____

6. NAME OF OPTOMETRIST/OPTHOMALOGIST:_____

7. HAVE YOU FALLEN IN THE PAST YEAR? **(AGES 65 AND OVER)**

   YES___ NO__ IF YES NUMBER OF FALLS_____IF YES NUMBER OF INJURIES_____

8. ARE YOU A SMOKER? YES_____NO_____ FORMER_____

9. DO YOU DRINK ALCOHOL? YES_____ NO_____ HOW OFTEN?_____

## DEPRESSION SCREENING

1. LITTLE INTEREST OR PLEASURE IN DOING THINGS?
   - ☐ YES
   - ☐ NO

2. FEELING DOWN, DEPRESSED OR HOPELESS?
   - ☐ YES
   - ☐ NO

IF ANSWERED YES TO THE FOLLOWING QUESTIONS, PLEASE TURN OVER →

# MD Partners of Englewood Hospital Medical Center

IF YES, PLEASE PROCEED TO THE FOLLOWING QUESTIONS:

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| 1) Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| 2) Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| 3) Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ | ☐ |
| 4) Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| 5) Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| 6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| 7) Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| 8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| 9) Thoughts that you would be better off dead or of hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |

IF ANSWERED YES TO THE FOLLOWING QUESTIONS, PLEASE TURN OVER