PLEASE PRINT CLEARLY - CENTRAL JERSEY HAND SURGERY - PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ SS#: _____ Email Address: _____

Sex: ◯ Male ◯ Female Marital Status: _____ Home Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone: _____ Occupation: _____

Employer Address: _____ ◯ Do NOT call me at work

Referring MD: _____ Phone: _____

Referring MD Address: _____

Family Physician: _____ Phone: _____

Family Physician Address: _____

Employment/ Student Status: ◯ Full time ◯ Part time ◯ Not Employed ◯ Self Employed ◯ Retired ◯ Military Duty

Guardian/ Spouse's Name: Relationship: Phone #:

Additional Information:

Race: ◯ Asian ◯ Black/African American ◯ American Indian ◯ White ◯ More than 1 race ◯ Unreported/ Refused to report

Ethnicity: ◯ Hispanic/ Latino ◯ Not Hispanic/ Latino ◯ Unreported/ Refused to report Language: _____

How did you hear about CJHS: Referred by name/ source:

Primary Insurance:

Insurance Company: _____ Specialist Copay: _____ Effective Date: _____

Insured's Name: _____ Address (If Different): _____

Relationship to insured: _____ Insured's Birthdate: _____ Insured's SS#: _____

ID#: Group #:

Secondary Insurance:

Insurance Company: _____ Specialist Copay: _____ Effective Date: _____

Insured's Name: _____ Address (If Different): _____

Relationship to insured: _____ Insured's Birthdate: _____ Insured's SS#: _____

ID#: Group #:

Tertiary Insurance:

Insurance Company: _____ Specialist Copay: _____ Effective Date: _____

Insured's Name: _____ Address (If Different): _____

Relationship to insured: _____ Insured's Birthdate: _____ Insured's SS#: _____

ID#: Group #:

If CJHS participates in your health insurance, we will bill your carrier for any eligible charges that you incur. We will assist you in obtaining authorization for HMO and Managed Care treatments, but **YOU** are responsible for making sure that the appropriate **referrals** are acquired and are **up to date** with the appropriate number of treatments approved.
You are responsible for the payment of any co-insurance amounts, non-covered charges, and denied claims.
If CJHS does not participate in your health insurance, you are responsible for payment of charges **at the time of service**. You are responsible for any balance remaining after ins. payment to our office. If your ins. co. has not paid a claim we submitted for you w/in 60 days, payments are your responsibility.
It is your responsibility to notify your insurance co., & obtain pre-authorization, if any surgery or hospital admission is planned. We will be happy to assist you in determining your likely balance due after expected insurance payment & can help arrange a method of payment. Your health insurance is a contract between you & your insurance co. We cannot accept responsibility for negotiating any type of settlement on a disputed claim if your pre-authorization is not obtained.
I hereby authorize payment from the insurance company to be sent directly to Central Jersey Hand Surgery for any service rendered to me by the group. I also authorize the release of medical information to my insurance company in order for Central Jersey Hand Surgery to complete the necessary ins. forms. I give permission for CJHS to appeal any denials or under payments received from your insurance company.
I am aware that the practice of medicine & surgery is not an exact science and acknowledge that no guarantees will be given to me concerning the results of any treatment or operation. Drs. Pess, Decker, Gabuzda, Atik and Fedorcik will attempt to improve the patient, but cannot return the patient to normal status.

Patient/Guardian's Signature: _____ Date: _____

Central Jersey Hand Surgery
Hand – Wrist – Forearm - Microsurgery
www.centraljerseyhand.com

234 Industrial Way West, Bld B, Eatontown, NJ 07724 ■ (732) 542-4477
535 Iron Bridge Road, Freehold, NJ 07728 ■ (732) 462-7700
780 Route 37 West, Toms River, NJ 08755 ■(732) 286-9000

PATIENT MEDICAL HISTORY QUESTIONNAIRE

***(This form will become part of your permanent medical record. Please print clearly and fill out accurately.)**

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Height: _____ Weight: _____ Ever had a flu vaccine? No Yes Date: _____ Pneumonia vaccine? No Yes Date: _____

Why are you here today? _____

Date of Onset: _____ **Hand Dominance: Right Left** Rate your pain: 0 -10 (10 being worst) _____/10

Referring Doctor: _____

Past Medical History (please circle all that apply to you):

Diabetes	High Blood Pressure	High cholesterol	Thyroid disease	Glaucoma
Heart disease	Heart attack (MI)	Congestive heart failure	Vascular disease	Aneurysm
Lyme disease	Bleeding disorder	Seizure disorder	Depression	Gout
Multiple Sclerosis	Enlarged prostate	Hepatitis: Type A B C	Gastric Reflux	Anemia
Stomach ulcer	Rheumatoid arthritis	HIV Positive	Liver disease	Sleep apnea
Cancer (types): _____		Kidney disease	Emphysema	Asthma

Please list any other medical conditions you have which are not listed above:

_____

Past Surgical History (Please circle all that apply to you and list the date of surgery)

Surgery	Date	Surgery	Date
Knee arthroscopy (Right / Left)		Shoulder arthroscopy (Right / Left)	
Joint replacement surgery (Knee / Hip)		Laparotomy	
Spine surgery (Neck/Back)		Hernia repair	
Eye surgery		Peripheral bypass surgery	
Coronary artery bypass graft		Cardiac catheterization	
Stents		Hysterectomy	

Please list any other surgeries you have had which are not listed above:

_____

List all other medications you are taking including non-prescription medications.

❍ I Am NOT taking any medications

	Medication #1	Medication #2	Medication #3	Medication #4
Name:				
Dosage:				
Frequency:				
Route:				
	Medication #5	Medication #6	Medication #7	Medication #8
Name:				
Dosage:				
Frequency:				
Route:				
Preferred Pharmacy:			**Town:**	
Phone #:				

List all Allergies including the associated reaction; include contact allergies such as latex, etc.:

❍ I DO NOT have any allergies

Allergy	Reaction	Allergy	Reaction

Patient Name: _____ Date of Birth: _____

Family Medical History (please circle all that apply to you):

Diabetes	High Blood Pressure	Heart Disease	Stroke
Seizures	Hepatitis	Rheumatoid Arthritis	Asthma
Kidney Disease	Dupuytren's Contracture	Malignant Hyperthermia	Bleeding Disorder

Cancer (types): _____

Please list any family medical conditions that are not listed above:

_____

Please circle the correct response:

Single Married Partnered Widowed Divorced

Do you presently or did you formerly smoke? Yes No Former How much do/did you smoke? Light Heavy Occasional

Indicate your alcohol use per week: None 1-6 7-14 15-More

Do you use illicit drugs? Yes No If yes, what kind: _____

Education Level: High School College Some College Graduate/Higher Other

Occupation: _____

Employer: _____

Sports Participation: Golf Tennis Football Baseball Basketball Running Yoga Gym Bowling

Review of Systems: (Please circle any of the following symptoms that you have experienced recently)			
Category:	**Symptoms:**		
Constitutional:	Fever	Night Sweats	Weight Loss
Eye:	Red Eyes	Blurring Vision	Vision Loss
Ears/Nose/Throat:	Nose Bleeds	Sore Throat	Hearing Loss
Cardiovascular:	Chest Pain	Palpitations	Leg Swelling
Respiratory:	Shortness of breath	Chronic Coughs	Wheezing
Gastrointestinal:	Nausea	Vomiting	Diarrhea
Genitourinary:	Burning w/urination	Blood in urine	Urinary incontinence
Skin:	Rash	Hives	Skin infection
Neurological:	Headache	Tremor	Seizures
Psychiatric:	Depression	Anxiety / Panic attacks	Suicidal ideation
Endocrine:	Excessive thirst	Cold intolerance	Excessive sweating
Hematological/Lymph:	Easy bruising	Swollen glands	Easy bleeding
Allergy/Immune:	Runny nose	Sinus Congestion	Itchy eyes

Please describe in detail the symptoms and treatment you have related to the problems circled above:

_____

_____

Any additional information that you would like the physician to know:

_____

_____

Patient Signature: _____ **Date:** _____

Reviewed by Dr. _____ Signature: _____ Date: _____

CENTRAL JERSEY HAND SURGERY LLC

Hand - Wrist - Forearm – Microsurgery

Gary M. Pess, M.D., FAAOS, FACS
Diplomate American Board of Orthopedic Surgery
Certificate of Added Qualification in Surgery of the Hand

Raymond G. Decker, Jr., M.D., FAAOS, FACS
Diplomate American Board of Orthopedic Surgery
Certificate of Added Qualification in Surgery of the Hand
Certified American Board of Independent Examiners

George M. Gabuzda, M.D. FAAOS, FACS
Diplomate American Board of Orthopedic Surgery
Certificate of Added Qualification in Surgery of the Hand

Teddy L. Atik, M.D.
Diplomate American Board of Orthopedic Surgery
Certificate of Added Qualification in Surgery of the Hand

Gregory G. Fedorcik, M.D., FACS
Certificate of Added Qualification in Surgery of the Hand

234 Industrial Way West
Building B
Eatontown, NJ 07724
Phone: 732-542-4477
Fax: 732-935-0355

535 Iron Bridge Rd.
Freehold, NJ 07728
Phone: 732-462-7700
Fax: 732-431-4770

Please refer all replies to
Eatontown Office

780 Route 37 West
Toms River, NJ 08753
Phone: 732-286-9000
Fax: 732-240-0036

Visit us on the Web at:
http://www.centraljerseyhand.com

Pain Medication Policy

These are our established guidelines for pain medications:

1. A copy of the prescription you were given will be photocopied and placed in your chart.
2. To acquire medication refills, you must notify our office between the hours of 9:00 AM – 3:00 PM, Monday through Friday (except Holidays). It may take up to **TWO** working days to call in medications.
3. After hours and on weekends, the doctor on call **WILL NOT** call in any additional prescriptions or refill any medications.
4. The doctor on call will only answer questions regarding complications from medications or from procedures.
5. If a prescription is stolen or lost, a refill will not be given until the date it was to be refilled. **THERE WILL BE NO EXCEPTIONS.**
6. Use of prescriptions more often than prescribed will not be refilled early.
7. It is your responsibility to inform our physician of any medications you are receiving from any other physicians.
8. **AUTOMATIC DISCHARGE FROM THE PRACTICE WILL OCCUR FOR ANY OF THE FOLLOWING REASONS:**
   …forgery or diversion of the prescriptions.
   …failure to comply with recommendations of the physician.
   …drug-seeking behaviors such as using medication more than recommended, repeatedly calling the physician after hours, repeated visits to the ER for pain, persistent use of pain medications beyond the expected postoperative period, failure to notify the physician that you are receiving medications from other physicians.
9. You may be referred to a Pain Management Specialist or asked to have an evaluation by a Psychiatrist or Psychologist to help manage your pain.

I have read and understand the above pain medication policy.

Patient/Guardian Signature: _____ Date:_____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say no to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home, office or cell phone) or to send mail to a different address. • We will say yes to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say no if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say yes unless a law requires us to share that information.
Get a list of those whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures for those about treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated.	• You can complain if you feel we have violated your rights by contacting our Privacy Officer at 2 Industrial Way West, Eatontown, NJ 07724 OR (732) 542-4477 • You can file a complaint with DHHS Office of Civil Rights. Visit www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. • Include your information in a hospital directory. • Contact you for fundraising efforts. *If you are not able to tell us your preference (for example, if you are unconscious) we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we never share your information unless you give us written permission	• Marketing purposes. • Sale of your information. • Most sharing of psychotherapy notes.
In the case of fundraising:	

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES & DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example*: A doctor treating you for an injury asks another doctor about your overall health condition.
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example*: We give information about you to your health insurance plan so it will pay for your services.
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example*: We use health information about you to manage your treatment and services.

OTHER USES & DISCLOSURES

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office and on our website.

Effective April 14, 2003 – Revised September 23, 2013

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NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print name of patient: _____ Date: _____

Signature of patient: _____ SSN: _____

For personal representative of the patient (if applicable):

Print name of personal representative: _____ Date: _____

Signature of personal representative: _____ Relationship to patient: _____

For practice use only:
Signature of practice Employee: _____ Date: _____

The following is an authorization for miscellaneous services this office uses. We will make every effort to abide by your instructions.
Please provide the following information:

Appointment Reminders/ Test Results (laboratory, x-rays, etc.):
If we need to reach you regarding an appointment or test results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours. Please check all items below that apply to you.

May we call to remind you of an appointment or regarding test results? ☐ Yes ☐ No

Please call me at the following number(s):

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

If we get an answering machine/voicemail, may we leave a message? ☐ Yes ☐ No

If we get a family member, may we leave a message? ☐ Yes ☐ No

Policy for discussing your medical information with family members:
Our office will never discuss your medical information with a family member unless you have authorized us to do so. Please indicate the family members authorized to discuss your medical care by checking all items that apply to you and providing the name(s) where applicable.

☐ Spouse _____

☐ Parent(s) _____

☐ Child(ren) _____

☐ Sibling(s) _____

☐ Other(s) _____