Sleep & Wellness Medical Associates, LLC

PATIENT HISTORY QUESTIONNAIRE

Name_____ **Date**_____

Pharmacy_____ **Pharmacy Number**_____

MEDICATIONS – PLEASE FILL OUT COMPLETELY AND ACCURATELY
PLEASE REFER TO YOUR MEDICATION BOTTLE(S)
IF ADDITIONAL SPACE IS NEEDED – PLEASE USE ADDITIONAL SHEET

Current Medications	Dose (mg)	How Often	How Many Pills Per Day
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____
7._____	_____	_____	_____
8._____	_____	_____	_____
9._____	_____	_____	_____
10._____	_____	_____	_____

PAST MEDICAL HISTORY

Please check any of the following health problems with which you have been diagnosed:

- ☐ Alcoholism
- ☐ Allergic rhinitis
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar disorder
- ☐ Cancer of _____
- ☐ Cataracts
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Gastric reflux Disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Irregular heart beat
- ☐ Kidney stones
- ☐ Migraine headaches
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate problems
- ☐ Shingles
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Vascular disease
- ☐ History of pain
- ☐ Injury

☐ Other: _____

PAST SURGICAL HISTORY

Type of Surgery	**Date (mm/yy)**
_____	_____

→

FAMILY HISTORY

Are there any diseases that run in your family: ☐ Yes ☐ No If yes, please list below:

Are there any close family members who are disabled? ☐ Yes ☐ No If yes, please list below:

Father: ☐ Alive ☐ Deceased Medical Problems:

Mother: ☐ Alive☐ Deceased Medical Problems:

Grandparents: ☐ Alive☐ Deceased Medical Problems:

Children: ☐ Alive☐ Deceased Medical Problems:

COMMENTS:

SOCIAL HISTORY

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

Children: How many: _____ How old are they: _____

Do you smoke cigarettes? ☐ Yes ☐ No How many packs per day?_____ Years? _____

Did you quit smoking? ☐ Yes ☐ No When? _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? _____ Years?_____

Did you quit drinking? ☐ Yes ☐ No When? _____

Have you used non-prescribed or illegal drugs? ☐ Yes ☐ No

What kind?_____

Employed: ☐ Yes ☐ No Status: ☐ Full-time ☐ Part-time

ALLERGIES

Drug Allergies: ☐ No Known Drug Allergies ☐ Yes, List the Drugs you are allergic to and reactions:

Food Allergies: ☐ No Known Food Allergies ☐ Yes, List the foods you are allergic to and reactions:

Other Health Issues you have not mentioned:

We appreciate your taking the time to complete this questionnaire.

Sleep and Wellness Medical Associates Patient Registration
31 E. Darrah Lane Lawrence Township, NJ 08648

Name:_____

Address :_____City_____State_____ZIP_____

Phone: (_____)_____Work: (_____)_____Cell: (_____) _____

Email: _____

Employer:_____Occupation: _____

Sex: Male Female Age:_____Date of Birth:_____Soc Sec #: _____

Marital Status: Single Married Separated Divorced Widowed

Spouse's/ Parent's Name:_____Contact Number: (___) _____

Emergency Contact Name:_____Contact Number: (___) _____

Referring Doctor:_____Phone Number: (___) _____

Insurance Information

Primary Insurance: _____

Name of Insured:_____Insured's Date of Birth_____

Secondary Insurance:_____

Name of Insured:_____Insured's Date of Birth_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AND ERISA REPRESENTATIVE DESIGNATION

I authorize and designate that payment of any health insurance or medical plan benefits be paid directly to Sleep and Wellness Medical Associates (SWMA) for any past, current, or future testing, medical services rendered, or supplies or medications provided.

I hereby authorize the release of information as to my health status, conditions, symptoms or treatment contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to SWMA all rights to payment and benefits and all legal and other health plan, ERISA plan, or insurance contract rights that I (or my child, spouse, or minor dependent) may have or had under my/our applicable health plan(s) or health insurance policy(ies) for past, current, or future services rendered. This assignment includes, but is not limited to, a designation that SWMA can act on my/our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due or were due to SWMA as a result of services rendered by SWMA, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer or in response to legal action by any such health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

Patient's Name: _____
(please print)

Patient's Signature: _____ Dated: _____
(If patient is a minor, signature of parent/guardian)

Sleep and Wellness Medical Associates,LLC

31 E. Darrah Lane

Lawrence Twp, NJ 08648

HIPAA Notice of Privacy Practices

It is the policy of Sleep and Wellness Medical Associates (SWMA) that all physicians and staff preserve the integrity and confidentiality of Protected Health Information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, physicians, and staff hold the necessary medical and PHI of our patients to the highest degree possible. Patients should not fear about providing information to our practice and its physicians and staff for purpose of treatment, payment and healthcare operations (TPO).

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your PHI to carry out treatment, payment, or health operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services.

Uses and Disclosures of Protected Information: Your PHI may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your PHI as necessary to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to or from to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition we may use a sign-in sheet at the registration desk or you will be asked to sign your name and indicate physician. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you for your appointments.

We may use or disclose your PHI in the following situation without your authorization. These may include: as Required By Law, Public Health Issues as required by law, Communicable Diseases Health Oversight, Abuse or Neglect; Food & Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI: This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who

may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. However, if your physician believes it is in your best interest medically, to permit use and disclose of your PHI, your PHI will not be restricted.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.

You have the right to have your physician amend your PHI: if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you via mail or when you are at our office of any changes. You then have the right to object or withdraw as provided in this notice.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, SWMA may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Sleep and Wellness Medical Associates' Notice of Privacy Practices for a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SWMA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office at 3836 Quakerbridge Road Suite 206, Hamilton, NJ 08619.

With my consent, SWMA may call my home or designated location and leave a message on voicemail or in person in reference to any items that assist the practice in caring out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____

__O.K to leave a message with detailed information

__ Leave a message with name of practice and call back number only

Work Telephone: _____

__ O.K to leave a message with detailed information

__Leave a message with name of practice and call back number only

I grant permission for you to discuss my care with the following person(s):

Name:_____Relationship:_____Phone Number: _____

Name:_____Relationship:_____Phone Number: _____

Name:_____Relationship:_____Phone Number: _____

By signing this form, I am consenting to SWMA's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, SWMA may decline to provide treatment to me.

Each dated signature is valid for one (1) year

_____ _____

Print name of patient/legal guardian Date

_____ _____

Signature of patient/legal guardian Date