Medical Alliance

OF SOUTHERN NEW JERSEY

1206 W. Sherman Ave. Bldg. 1*Vineland, NJ 08360-6916*Tel. (856) 462-6250*Fax (856) 691-8325

WELCOME TO OUR OFFICE

You have an appointment with:

Dr. Donald C. Huston DO
Dr. Maurice S. Sheetz MD
Dr. Per Montero-Pearson MD

On:_____ @ _____am/pm

For your convenience, I have included new patient paperwork to be filled out and brought to your first appointment.

(PLEASE DO NOT MAIL BACK)

Please also bring the following with you to your appointment:

INSURANCE CARD AND REFERRAL (IF REQUIRED BY INSURANCE COMPANY).

YOUR INSURANCE COPAY (IF REQUIRED BY INSURANCE COMPANY).

ANY RECENT TEST RESULTS (IE: LABS, X-RAYS, DEXA SCAN, MRI, CT SCAN ETC).

Welcome to Medical Alliance of Southern New Jersey P.C.

Patient Information: Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone#: Home _____ Cell: _____ Work: _____

Email Address: _____

Date of Birth: _____ Sex: Male _____ Female _____ Race: _____

SS#: _____ Marital Status: _____

Work Status: _____ Name of Employer: _____

Emergency Contact & Phone #: _____

Primary Doctor Name & Phone#: _____

Referring Doctor Name & Phone#: _____

Reason for Visit:

_____

_____

Allergies:
(Please indicate any allergies to medications, dyes, foods, herbs, metals, latex or other substances.)

_____

_____

_____

Health Maintenance:
(Please place a checkmark next to the items that you have had done in the past and the date)

TEST	MOST RECENT DATE DONE
Bone Density Scan	_____
Cholesterol	_____
Colonoscopy	_____
ECHO	_____
EKG	_____
Flu Immunization	_____
Hepatitis B Vaccine	_____
HgbA1C	_____
Mammogram	_____
Microalbumin	_____
Pneumovax Immunization	_____
PSA Test	_____
TSH	_____
Tuberculosis Test	_____
Urinalysis	_____
Stool for Occult Blood	_____

Smoking HX:

_____Never Smoker
_____Former Smoker: Year/Age Started _____ Year/Age Stopped _____
_____Current Smoker: Year/Age Started_____ How Much _____

Cigarettes _____ Cigars _____ (check all that apply)

Alcohol Hx:

_____Never Used Alcohol
_____Formerly Used Alcohol: Year/Age Started _____ Year/Age Stopped _____
_____Currently Use Alcohol: Year/Age Started _____ Type _____ How often _____

Family HX: (Includes parents, grandparents, siblings, children)

Condition	Family Member	Age Diagnosed
Cancer (Type)		
High Blood Pressure		
Heart Disease (Type)		
Diabetes (Type)		
Stroke		
Mental Disease		
Kidney Disease		
Bleeding Disorders		
Drug or Alcohol Abuse		

Surgery Hx:

Date	Surgical Procedure

Hospitalizations:

Date	Reason Hospitalized

Do you have a living will? _____No _____Yes
Do you have a donor card? _____No _____Yes
Do you have any barriers that may impede the provider and or staff from providing medical care to you (language, visual and/or auditory deficits, physical or mental handicap, cultural/religious custom)?
_____No _____Yes, please explain _____

Patient Name: _____

Past Medical History:
(Please place a checkmark next to any condition that you have had or are currently experiencing.)

_____AIDS
_____Abdom. Aortic Aneurysm
_____Alcholism
_____Alzheimer's Disease
_____Anemia
_____Anemia of Chronic Dis.
_____Anemia, B12 Deficiency
_____Anemia, Iron Deficiency
_____Angina
_____Anorexia Nervosa
_____Anxiety
_____Arteriosclerosis
_____Arthritis
_____Arthritis, Osteo
_____Arthritis, Rheumatoid
_____Asthma
_____Atrial Fibrillation
_____Atrial Flutter
_____Ben. Prostatic Hypertrophy
_____Bladder Infection
_____Bleeding Disorder
_____Bronchitis
_____Bulimia
_____Cancer (indicate Location)
_____
_____
_____
_____Cardiac Arrhythmia
_____Carotid Artery Stenosis
_____Cataracts
_____Cerebrovascular Accident
_____Chest Pain/Tightness
_____COPD
_____Cirrhosis
_____Colitis
_____Colon Disorder
_____Colon Polyp
_____Congestive Heart Failure
_____Coronary Artery Disease
_____Crohn's Disease
_____Deep Vein Thrombosis
_____Dementia
_____Depression
_____Dermatitis
_____Diabetes, Gestational
_____Diabetes, Insulin Dep .
_____Diabetes, Non-Insulin Dep.
_____Diabetes, Type 1
_____Diabetes, Type 2
_____Difficulty Urinating
_____Diverticulitis
_____Diverticulosis
_____Drug Addiction
_____Eczema
_____Emphysema
_____Enlarged Prostate
_____Epilepsy
_____Erectile Dysfunction
_____Esophagitis
_____Gallstones
_____Gastroesphageal Reflux Disease
_____Gout
_____HIV Infection
_____Headache
_____Hearing Loss
_____Heart Attack
_____Heart Attack, Premature
_____Heart Disease
_____Heart Failure
_____Heart Murmur
_____Heart Valve Problem
_____Heartburn
_____Hepatitis A
_____Hepatitis B
_____Hepatitis C
_____Hernia, Abdominal
_____Hernia, Femoral
_____Hernia, Hiatal
_____Hernia, Inguinal
_____Hernia, Umbilical
_____Herpes Simplex
_____High Blood Pressure
_____High Cholesterol
_____Hives
_____Hodgkin's Disease
_____Hypercholesterolemia
_____Hypertension
_____Hyperthyroidism
_____Hypothyroidism
_____Immune Function Disorder
_____Incontinence
_____Infectious Disease
_____Leukemia
_____Liver Disease
_____Lung Disease
_____Lupus
_____Melanoma
_____Mental Illness
_____Migraine
_____Mumps
_____Muscle Disorder
_____Myocardial Infarction
_____Night Sweats
_____Non-Hodgkin's Lymphoma
_____Obesity
_____Osteoporosis
_____Palpitations
_____Pancreatitis
_____Parkinson's Disease
_____Peptic Ulcer Disease
_____Peripheral Vascular Dis.
_____Phlebitis
_____Pneumonia
_____Prostate Disease
_____Psoriasis
_____Pulmonary Embolism
_____Rheumatic Fever
_____Rubella
_____Scarlet Fever
_____Seizure Disorder
_____Shortness of Breath
_____Sickle Cell Anemia
_____Sinusitis
_____Stroke
_____Stroke, Premature
_____Swollen Ankles
_____Thyroid Disease
_____Transient Ischemic Attack
_____Trouble Urinating
_____Tuberculosis
_____Tumors
_____Ulcer, Duondenal
_____Ulcer, Gastric
_____Ulcer, Peptic
_____Urethritis
_____Venous Insufficiency
_____Vertigo
_____Weight Gain
_____Weight Loss
_____
_____
_____

Patients Name: _____

Authorization for Release of Medical Records

I hereby give my authorization to any hospital, physician or other facility that has treated or examined me to release any and all medical records to Medical Alliance of Southern New Jersey. I also authorize Medical Alliance of Southern New Jersey to release any and all medical records necessary for evaluation of my medical conditions to any hospital, physician, or other facility that is or will be treating me.

_____ _____

Signature of Patient/ Responsible Party Date

Authorization to Use and Disclose Health Information

Under the Health Insurance Portability & Accountability Act of 1996, you have certain rights to privacy regarding your protected health information. This information will be used to direct treatment among healthcare providers, obtain payment from third party payers and conduct normal healthcare operations. A more complete description of these uses in included in the **Notice of Privacy Practices**.

At Medical Alliance of Southern New Jersey, we protect your personal, health, and financial information by complying with the national standards to protect the privacy of personal healthcare information. However, our healthcare professionals may disclose personal, health, or financial information about patients if given permission to do so and only to those in which you identify.

Please list below those persons whom you wish to have access to your personal, health, and financial information. Again, this information will only be released to those listed below:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

My signature also gives permission to leave a message on my home/work answering machine/voice mail and my cellular phone.

I acknowledge that Medical Alliance of Southern New Jersey **Notice of Privacy Practices** has been made available to me and I understand that once Medical Alliance of Southern New Jersey discloses any information to any of the above persons, that Medical Alliance of Southern New Jersey cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable Federal and State Law governing the use and disclosure of my health information. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Medical Alliance of Southern New Jersey to use or disclose my health information in the matter described and to those that I have designated above.

_____ _____

Signature of Patient/ Responsible Party Date

TERM: This authorization will remain in effect from the date of authorization until otherwise notified in writing.

Patient Name: _____

MEDICATION RECORD
(VITAMIN & HERB SUPPLEMENT)

PATIENT _____ CHART # _____

SSN _____ DOB _____ PHARMACY _____

MEDICATION	DOSAGE	DIRECTIONS

Medical Alliance of Southern New Jersey, P.C.

Medication Treatment Contract

The purpose of this contract is to provide a clear and mutual understanding between patient and provider regarding the safe and effective use of opioid analgesics.

The purpose of opioid analgesics is to decrease your pain. Some patients will have an excellent response. They will experience a noticeable decline in their pain without interfering side effects, (other than constipation), such as sedation and nausea. Other patients will experience side effects, however, they will be mild and go away in a couple of weeks, and; there will be still other patients whose side effects will be severe enough to interfere with their continued use of the opioid. If this happens to you, it is important that you notify your physician at once. He or she can prescribe other medicines to alleviate your side effects or, if necessary, replace the opioid with another type of medication.

Opioids may also cause unintended psychological effects such as false sense of well-being and the feeling of being better able to cope with problems. Sometimes patients who experience these effects may use their medicine in a way other than prescribed.

The following definitions are important for you to understand. Please read them carefully:

Physical Dependence is a pharmacologic property of certain drugs, such as caffeine and opioids that causes changes in the body. Abruptly stopping to take these drugs could result in a "withdrawal" response. Physical dependence will occur in all patients who use opioid analgesics on a regular basis. Physical dependence should not be confused with addiction.

Addiction is a psychological and behavioral syndrome in which there is a drug-craving and drug-seeking behavior for the purposes other than those intended by your physician. For example, addictive behavior would include increasing your usual dose of opioid (without prior discussion with your physician) for psychological benefit during a stressful situation. The risk of addiction in patients who do not have a history of addiction (to any substance) is extremely low.

Tolerance is a pharmacologic property of certain drugs such as opioids defined by the need for increasing the dose to maintain effect. This does not appear to be a treatment issue in the pain population (unlike the addict population).

Informed Consent

I understand that the use of opioid analgesics can be a safe and effective treatment for my chronic pain. I also understand her exists a risk of developing an addiction disorder. However, I also understand that this is extremely rare in patients who have no prior addiction history. I agree not to increase my opioid dose unless I discuss this with my doctor first. I agree to fill any prescriptions at one pharmacy. I will not obtain opioid analgesics from any other health professional unless I first discuss this with my doctor. If I require treatment in an emergency room (ER) which necessitates opioids, I will inform the ER physician of any present medication regimen and ask her/him to call my doctor. I will not sell or share my medication. If my medication is lost or stolen, I will report this to my local police department and obtain a stolen/missing item report for verification.

Patient Name: _____ Signature: _____

Date: _____

Pharmacy Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____