RHEUMATOLOGY CENTER OF NEW JERSEY

56 UNION AVENUE | SOMERVILLE, NEW JERSEY 08876

○ Ahmed Abdel-Megid, MD ○ Amanda Borham, MD ○ Humaira Adenwalla, MD

PATIENT INFORMATION

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Ph:_(____)_____ Cell Ph:_(____)_____ Work Ph:_(____)_____

***Email:* (Required)**_____

SSN:_____ Marital Status: S M D W DP Sex: ○ M ○ F

Primary Care Physician:_____ Phone:_(____)_____

Emergency Contact Name:_____ Relationship:_____

Home Ph:_(____)_____ Cell Ph:_(____)_____

Pharmacy Name: _____ ***Phone:*** _(____)_____

ACCOUNT INFORMATION

Responsible Party: ○ Self ○ Spouse ○ Parent ○ Other

Guarantor (if other than self):_____ Relationship:_____

Address (if different from above):_____

Home Ph:_(____)_____ Cell Ph:_(____)_____ Work Ph:_(____)_____

INSURANCE INFORMATION

Insurance Company: _____

Subscriber:_____ Relationship:_____

Date of Birth:_____ SSN:_____ Sex: ○ M ○ F

Address:_____

Phone Number :_(____)_____

ADDITIONAL INFORMATION

Preferred Language: _____ Ethnicity:_____ Race:_____

Ethnicity Options: Hispanic/Latino, Non-Hispanic/Non-Latino, Not Reported, Declined

Race Options: White, African American, Asian, Native Hawaiian/Pasific Islander, American Indian/Alaska Native, Multiple Races, Not Reported, Declined

ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION

I certify that the information provided herein is correct and accurate and hereby authorize Rheumatology Center of New Jersey to submit claims to Medicare, Medigap and commericial payers on my behalf. I assign any payment and/or benefit from these payers for these services to Rheumatology Center of New Jersey. I further authorize the release of any medical records necessary for the adjudicationand payment of these claims or any authorizations for services orprocedures rendered or to be redered. I understand balances for deductibles, co-insurance, co-payments and non covered services are my financial responsibility. If any balances become delinquent and are referred for further further collection activity, I may become liable for any cost of collection including collections fees, court fees and legal fees.

_____

Signature Date

Name: _____ DOB: _____ ○ M ○ F

Reason for Today's Visit:

Present Medications:

Past Medical History:
(Briefly list unusual CHILDHOOD diseases, MAJOR SURGERY, and MAJOR ILLNESS, other than your current complaint.)

Family History: (Indicate any major medical conditions that run in your family, especially a history of Gout or Psoriasis)

Allergies to Medications?

Social History:
Occupation: _____

Children (how many): _____

Do you smoke? _____ How Long? _____

Do you drink alcohol? _____ How much? _____

Condition	Y	N	Condition	Y	N
Skin rash or Psoriasis			Recurrent chest pain		
Pitting or infection of nails			Pleurisy		
Hardening or tightening of skin			Asthma or bronchitis		
Recent of Unexplained hair loss			Recurrent cough or vomitting of blood		
Recurrent sores on/in penis or vagina			Recent nausea or vomitting		
Frequent or recurring mouth sores			Stomach ulcer or intestinal trouble		
Recurrent conjunctivitis or pink eye			Stomach pain or heartburn		
Iritis, Uveitis or red eye			Hemorrhoids or colitis		
Anemia or blood disease			Frequent loose bowel movements		
Severe bleeding problems			Hepatitis, liver trouble or jaundice		
Frequent headache			Kidney or bladder disorder		
New excessive fatigue			Psychiatric or psychological treatment		
Emotional or nervous problems			Epilepsy, fits or convulsions		
Depression			History of recurrent cancer or tumors		
Recent progress or recurrent back pain other then the occational lower back ache?					
Inability to produce normal amounts of saliva?					
Difficulty in making tears, dryness or gritty feeling of the eyes on awakening?					
On exposure to sunlight, do you become ill, develop aching joints or severe skin rash?					
Have you experienced a miscarraige? If so how many?					
Raynaud's Syndrome (hands turn blue on exposure to the cold)?					
Have you been bitten by or removed any ticks?					
Inflammation of your veins or blood clots?					
Is there any compensation claim pending as a result of an injury or accident?					
Have you recently been out of the United States?					
Have you been seen by a Rheumatologist before?					
If so, Name:			Phone:		

_____
Patient Name

_____
Patient Signature Date

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Initials

OFFICE POLICIES

_____ I understand that if I fail to cancel my appointment within 24 hours of my scheduled time, I will be charged a $50.00 fee. I understand that Medicare and other commercial insurance companies will not reimburse me for this fee. By signing I am agreeing to these terms.

_____ I understand that if my check is returned, there will be a $35 charge in addition to the money owed.

_____ I understand that it is my responsibility to pay any co-pays, co-insurance and deductibles at the time of service.

_____ I understand that it is my responsibility, if required by my insurance, to bring a valid referral with me at the time of service. If I do not, I understand that the insurance company may not pay RCNJ and therefore I will be fully responsible for the cost of my visit. By signing I am agreeing to these terms.

_____ I understand that RCNJ will make every effort to explain the cost of visits, medication and procedures but it is my responsibility to be aware of my insurance companies reimbursement policies and guidelines. I understand and acknowledge that I am fully responsible for anything they do not cover. By signing I am agreeing to these terms.

_____ I give permission to leave detailed messages (appointments, payments etc) on the phone number on file.

_____ I give permission to leave test results (treatment, labs) on the phone number on file.

_____ I understand all test results must be reviewed by a physician during an office visit before copies of results are given.

_____ If another doctors office requires a copy, I will have them call RCNJ directly to make the request.

I authorize the release of information including diagnosis and/or records incuding examinations rendered to me and claim information. This information may be released to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

○ Do not release my information to anyone.

(This release of information will remain in effect until terminated by me in writing)

_____

Patient Name

_____

Patient Signature Date

Patient Acknowledgement of Receipt of Privacy Practices Notice

I, _____, hereby acknowledge that I have reviewed and received a copy of this offices Notice of Privacy Practice explaining:

- ☐ How this office will use and disclose my protected health information.
- ☐ My privacy rights in regards to my protected health information.
- ☐ This offices obligation concerning the use and disclosure of my protected health information.

I understand that this Notice of Privacy Practices may be revised and that I am entiltitld to recieve a copy of any revised Notice of Privay Practices upon request.

I also understand that if I have any concerns, I may contact:

Rheumatology Center of New Jersey
56 Union Avenue
Somerville, New Jersey 08876

Phone No. (908) 722-5380

For additonal information, visit www.hhs.gov/ocr/privacy/

Patient or Patient Representative

Signature: _____ Date: _____

OFFICE USE ONLY:

We made a good faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of our efforts, we were unable to obtain a signed acknolwedgement for the following reason:

- ☐ Patient refused to sign (date of refusal) _____/_____/_____
- ☐ Communication barriers prevented obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other:

Attempt made by: _____ Date: _____

RCNJ RHEUMATOLOGY CENTER OF NEW JERSEY

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Amanda Borham, M.D.
Humaira Adenwalla, M.D.
Jennifer Sidiropoulos, PA-C
Biagio Como, PA-C

BONE HEALTH (OSTEOPOROSIS/OSTEOPENIA) SCREENING QUESTIONNAIRE

TODAYS DATE:_____

LAST NAME: _____ FIRST NAME: _____

DOB: _____ AGE: _____ GENDER: _____

WHICH PROVIDER ARE YOU SEEING TODAY? [ ] Dr.Megid // [ ] Dr. Adenwalla
[ ] Dr. Borham // [ ] Jennifer Sidiropolous, PA-C // [ ] Biagio Como, PA-C

RISK FACTORS:

Have you ever fractured/broken a bone? [ ] YES [ ] NO
Has your mother/father ever fractured/broken a bone? [ ] YES [ ] NO
Do you smoke or use tobacco products? [ ] YES [ ] NO
Do you drink three or more alcoholic drinks a day? [ ] YES [ ] NO
Are you on steroids/immunosuppressants? [ ] YES [ ] NO
Do you have rheumatoid arthritis? [ ] YES [ ] NO
Have you ever had a bone density test (DEXA) to check for Osteoporosis/Osteopenia? [ ] YES [ ] NO

If you had a bone density test:
Where? _____ Date of test: _____
Do you know the results? [ ] normal // [ ] osteopenia // [ ] osteoporosis

FOR STAFF USE ONLY:

no risk factors

F AGE 50-64 / M AGE 50-69 → NO DEXA REQUIRED

WITH RISK FACTORS FROM ABOVE
F AGE 50-64 / M AGE 50-69 → PROCEED TO ORDER DEXA

56 Union Avenue I Somerville, New Jersey 08876
I I Centre Driver Suite B I Monroe, New Jersey 08831
8100 Wescott Drive, Suite 303 | Flemington, New Jersey 08822
281 Witherspoon, New Jersey, Suite 120 | Princeton, New Jersey 08540

Phone (908) 722-5380
Fax (908) 685-7501

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PATIENT RESPONSIBILTY
FOR FOLLOW-UP CARE PLEDGE

I _____ hereby acknowledge and understand that even with the best training, skill and
(print name)
experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment /outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, and MRI, or CT scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Signature_____ Date_____

56 Union Avenue I Somerville, New Jersey 08876
11 Centre Driver Suite B I Monroe, New Jersey 08831
194 State Route 31 Suite 102 | Flemington, New Jersey 08822
281 Witherspoon, New Jersey, Suite 120 | Princeton, New Jersey 08540

Phone (908) 722-5380
Fax (908) 685-7501