370 SUMMIT AVENUE • ALLEN N. SAPADIN, M.D. • HACKENSACK, NJ 07601

PATIENT INFORMATION: FIRST NAME: _____ MIDDLE INITIAL: _____

LAST NAME: _____ ADDRESS: STREET _____

CITY _____ STATE _____ ZIP CODE _____

BIRTH DATE: _____ AGE: _____ EMAIL ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ S.S.N.: _____ SEX: MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED STATUS: EMPLOYED RETIRED STUDENT UNEMPLOYED

OCCUPATION: _____ EMPLOYER NAME: _____

REFERRING PHYSICIAN: _____ PHONE#: _____

PRIMARY CARE PHYSICIAN: _____ PHONE#: _____

PRIMARY INSURANCE INFORMATION: NAME OF INSURANCE COMPANY: _____

ID#: _____ GROUP#: _____

PRIMARY CARD HOLDER'S RELATIONSHIP TO PATIENT: PARENT SPOUSE SELF OTHER

SEX: M F (IF **OTHER** THAN ***SELF***, COMPLETE **REMAINING** PORTION.)

PRIMARY CARD HOLDER'S FIRST NAME: _____ MIDDLE INITIAL: _____

PRIMARY CARD HOLDER'S LAST NAME: _____

HOME PHONE: _____ WORK PHONE: _____

BIRTH DATE: _____ S.S.N.: _____

OCCUPATION: _____ EMPLOYER NAME: _____

SECONDARY INSURANCE INFORMATION: NAME OF INSURANCE COMPANY: _____

ID#: _____ GROUP#: _____

PRIMARY CARD HOLDER'S RELATIONSHIP TO PATIENT: PARENT SPOUSE SELF OTHER

SEX: M F (IF **OTHER** THAN ***SELF***, COMPLETE **REMAINING** PORTION.)

PRIMARY CARD HOLDER'S FIRST NAME: _____ MIDDLE INITIAL: _____

PRIMARY CARD HOLDER'S LAST NAME: _____

HOME PHONE: _____ WORK PHONE: _____

BIRTH DATE: _____ S.S.N.: _____

OCCUPATION: _____ EMPLOYER NAME: _____

EMERGENCY CONTACT INFORMATION: FULL NAME: _____

RELATIONSHIP: _____ PHONE#: _____

Signature: _____ Date: _____

(Signature of insured or authorized person, patient, or parent of minor) (Today's Date)

Insurance Information - Co-payments and Deductibles

Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections interest and/or a collection fee, at the provider's current rate may be charged on all balances owing to the provider that are past due. Your signature below signifies your understanding and wiliness to comply with this policy.

Initial_____

Referral Information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that should I fail to have a valid referral for my visits; and my appointment will have to be rescheduled.

Initial_____

Insurance Cards

New patients or those patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier at your convenience for reimbursement. I understand by initialing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Initial_____

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Dr. Sapadin's office from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

Name of Individual (please print)	**Relationship to Patient**

Notice of Privacy Policy Patient Acknowledgement – NJS LICENSE #MA53444

I understand that under the Health Insurance Portability Accountability Act of 1998. I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood the Notice of Privacy Policy for the above named Provider.

The provider reserves the right to change the terms of the Notice or Privacy Policy. I understand the Provider will supply a current Notice of Privacy Policy upon request.

I certify that the information that I have provided is correct. I authorize the release of medical information if necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

Signature:_____ Date: _____

(Signature of insured or authorized person, patient, or parent of minor) (Today's Date)

Allen Sapadin MD
370 Summit Ave
Hackensack, NJ 07601

Name:_____ Date:_____

History and Intake Form

Why are you here today?

1.

2.

3.

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
BPH	Hepatitis	Seizures
Breast Cancer	High Blood pressure	Stroke
Colon Cancer	HIV/AIDS	Pacemaker
COPD	High Cholesterol	
Coronary Artery Disease	Thyroid Problems (Hyper or Hypo)	NONE

Other _____

Past Surgical History: (please list below)

-

_____

_____

_____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	
		NONE

Other _____

Allen Sapadin MD
370 Summit Ave
Hackensack, NJ 07601

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Medications: (Please enter all current medications)

_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
Never Smoked
Quit: Former Smoker
Smokes Less Than Daily
Smokes Daily

Alcohol Use:
EtOH- None
EtOH- less than 1 drink per day
EtOH- 1 to 2 drinks per day
EtOH- 3 or more drinks per day

Do you have a family history of non-melanoma skin cancer? Yes No
If yes, which relative(s)?_____

Pharmacy Name:_____
Street:_____ Zip code:_____

For Females Only:
Are you Pregnant or Breast Feeding? Yes or No
Are you planning a pregnancy? Yes or No
Do you have a regular cycle? Yes or No

Race:_____

Preferred Language:_____

Ethnic Group: Hispanic or Latino Not Hispanic or Latino