



DEMOGRAPHICS	NAME:	<i>FIRST</i> _____ <i>M.I.</i> _____ <i>LAST</i> _____		
	ADDRESS:	_____ <i>APT NO.</i> _____		
	CITY/ STATE/ ZIP:	_____		
	HOME PHONE:	_____		
	CELL PHONE:	_____		
	HOW DID YOU HEAR ABOUT OUR OFFICE:	<input type="checkbox"/> ANOTHER PROVIDER: NAME: _____ CITY/STATE: _____ <input type="checkbox"/> ONLINE – SEARCH ENGINE/WEBSITE: _____ <input type="checkbox"/> PATIENT		
	DATE OF BIRTH:	_____	SEX:	<input type="checkbox"/> F <input type="checkbox"/> M
			SSN:	_____
	MARITAL STATUS:	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> PARTNER <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED		
EMERGENCY CONTACT:	<i>NAME:</i> _____	<i>RELATION:</i> _____	<i>PHONE #:</i> _____	

IF WE COLLECTED YOUR INSURANCE CARD(S), ONLY FILL IN THE SUBSCRIBER NAME, RELATION, AND DATE OF BIRTH IF IT IS NOT SELF.

INSURANCE	PRIMARY:	_____		
	SUBSCRIBER ID:	_____		
	GROUP NO:	_____		
	SUBSCRIBER (IF NOT SELF):	<i>NAME:</i> _____	<i>RELATION:</i> _____	<i>DATE OF BIRTH:</i> _____
	SECONDARY:	<input type="checkbox"/> N/A		
	SUBSCRIBER ID:	_____		
	GROUP NO:	_____		
	SUBSCRIBER (IF NOT SELF):	<i>NAME:</i> _____	<i>RELATION:</i> _____	<i>DATE OF BIRTH:</i> _____

WORKERS COMPENSATION	IS TODAY'S VISIT RELATED TO A WORKERS COMP OR NO FAULT?:	<input type="checkbox"/> No <input type="checkbox"/> Workers Comp <input type="checkbox"/> No Fault		
	DATE OF ACCIDENT:	_____		
	IF SO, PLEASE LIST INSURANCE NAME & ADDRESS:	_____		
	CLAIM #:	_____		
	ADJUSTER'S NAME:	_____	ADJUSTER'S TEL NUMBER:	_____
	IF YOU HAVE AN ATTORNEY, PLEASE PROVIDE NAME AND PHONE NUMBER:	_____		

NOTICE OF PRIVACY PRACTICES	PLEASE READ:	<p><i>The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Sovereign Medical Group is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care provider that jointly perform payment activities and business operations with our Practice. "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 or condition and related health care services. PLEASE REVIEW IT CAREFULLY. This signature indicates you were offered /received a copy of the Notice of Privacy Practices.)</i></p>		
	DATE:			
	SIGNATURE:	<p>x</p> <p><input type="checkbox"/> PATIENT UNABLE TO SIGN DUE TO MEDICAL REASON <input type="checkbox"/> PATIENT REFUSES TO SIGN</p>		
E-RX CONSENT	PLEASE READ:	<p>Sovereign Medical Group implements ePrescribing at our office. ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software also lets your doctor see important information, like drug interactions and prescription history. The benefits to you are reduced possibility of medical errors, less chance of adverse drug reactions, fewer trips to drop off at the pharmacy and a safer, faster, easier way to get your prescription filled. I agree that Sovereign Medical Group may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.</p>		
	DATE:		SIGNATURE:	x

Do you have an Advance Healthcare Directive?: NO YES

IF YES, PLEASE PROVIDE THE OFFICE WITH A COPY WHEN POSSIBLE.

ADDITIONAL INFORMATION	EMAIL ADDRESS:			
	RACE:	<input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE HAWAIIAN/PACIFIC ISLANDER <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> HISPANIC <input type="checkbox"/> OTHER RACE <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> REFUSE TO REPORT		
	ETHNICITY:	<input type="checkbox"/> HISPANIC <input type="checkbox"/> NOT HISPANIC <input type="checkbox"/> REFUSE TO REPORT		
	LANGUAGE:			
	PHARMACY (NAME/CITY):			

FINANCIAL RESPONSIBILITY:	PLEASE READ:	<p>FINANCIAL RESPONSIBILITY: You are responsible to supply our staff with your insurance ID cards. We will automatically file the claim for you; however, you are responsible for any deductible or co-pay due at the time of service as described by your insurance policy. If any of the procedures performed here are not covered under your plan, you will be financially responsible for full payment. You hereby guarantee payment in full to Sovereign Medical Group for all charges for services rendered and/or charges exceeding third party payments (except when prohibited by law or under contract). You also authorize Sovereign Medical Group to release to government agencies insurance carriers and others who may be financially liable for the services, all information necessary to pre-authorize services, determine medical necessity and/or the extent or amount of liability and challenge denials of medical necessity. You hereby assign all amounts payable for services rendered to Sovereign Medical Group. You understand that this constitutes a waiver of confidentiality under 42 C > F.R. part 2 (drug and alcohol records) and N.J.S.A. 26: 5c-1 et seq. (FTW and AIDS records) and that this authorization is revocable, except to the extent that action has been taken in reliance thereon and will otherwise remain in force indefinitely in order to effectuate the purpose for which it is given. It is your responsibility to understand which insurance plans SMG participates with. The bill is your responsibility. Your insurance policy is a contract between you and your insurance company. Our office is not a part of the contract. We are happy to file your claim for you directly with you insurance company; however, the ultimate responsibility for payment is yours. You certify that the information given to you in applying for payment under the Title XVIII of the Social Security Act is correct. You authorize any holder of medical or other information to release to the Social Security Administration or its intermediaries or carries the information necessary for this or related to the Medicare claim. You request that payment of authorize benefits be made on your behalf. You hereby request and consent to, examination and treatment (including lab procedures, diagnostic and medical/surgical) rendered by Sovereign Medical Group and their associates. You also consent to the removal of specimens taken by lab or pathology examination. It is your responsibility to understand which lab your insurance company affiliates with. Our office will not be held liable for services rendered to you by a non-participating lab. We accept cash, check, money order, and credit cards. There is a \$25.00 fee for any returned check. Please be aware in the event your bill remains unpaid, we are forced to use a collection agency and you will be responsible for all costs associated with the process. Do not hesitate to call our office with any billing questions or concerns. Phone: (201) 703-5500. PLEASE NOTE: IF YOU DO NOT SHOW FOR YOUR SCHEDULED APPOINTMENT(S) WITHOUT CALLING THE OFFICE TO CANCEL/RESCHEDULE, YOU WILL BE CHARGED \$25. I certify that I have read this form and understand its contents. I also acknowledge no guarantees have been made to me as to the results of exams or treatment.</p>		
	DATE:		SIGNATURE:	x

PRINT NAME (FIRST, M.I., LAST): _____

MEDICAL HISTORY	REASON FOR TODAY'S VISIT:			
	LOCATION OF PAIN:		DURATION OF PROBLEM (PAIN):	
	QUALITY OF PAIN:	<input type="checkbox"/> SHARP <input type="checkbox"/> BURNING <input type="checkbox"/> DULL <input type="checkbox"/> ACHING		SEVERITY OF PAIN: <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE
	ASSOCIATED SIGNS/SYMPTOMS:			
	LIST ALL CURRENT/PAST MEDICAL ISSUES:			
	ALLERGIES TO MEDS/FOOD?:	<input type="checkbox"/> NO <input type="checkbox"/> YES <i>IF YES, PLEASE LIST:</i>		

PLEASE LIST ALL MEDICATIONS & VITAMINS, YOU ARE TAKING:

	<i>MEDICATION</i>	<i>DOSE</i>	<i>FREQUENCY</i>
CURRENT MEDICATION(S)			

MEDICAL HISTORY	PAST SURGERIES:			
	PAST HOSPITALIZATIONS:			
	FAMILY HISTORY			
	MOTHER:	<input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED		HEALTH ISSUES:
	FATHER:	<input type="checkbox"/> ALIVE <input type="checkbox"/> DECEASED		HEALTH ISSUES:
	SIBLING(S):	<input type="checkbox"/> N/A		
		BROTHER(S):	HOW MANY:	HEALTH ISSUES:
		SISTER(S):	HOW MANY:	HEALTH ISSUES:
	CHILDREN:	<input type="checkbox"/> N/A		
		SON(S):	HOW MANY:	HEALTH ISSUE(S):
	DAUGHTER(S):	HOW MANY:	HEALTH ISSUE(S):	

PRINT NAME (FIRST, M.I., LAST): _____

SOCIAL HISTORY	
DO YOU SMOKE CIGARETTES, CIGARS, AND/OR CHEW TOBACCO? <input type="checkbox"/> NO <input type="checkbox"/> YES	IF NO, DID YOU USED TO? <input type="checkbox"/> NO <input type="checkbox"/> YES APPROXIMATELY WHEN DID YOU QUIT?:
IF YES, HOW OFTEN DO YOU SMOKE?: <input type="checkbox"/> EVERY DAY <input type="checkbox"/> MOST DAYS	QUANTITY PER DAY:
HAVE YOU HAD ANY ALCOHOLIC BEVERAGE IN THE PAST YEAR?: <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, HOW OFTEN DID YOU CONSUME AN ALCOHOLIC BEVERAGE WITHIN THE PAST YEAR: <input type="checkbox"/> MONTHLY OR LESS <input type="checkbox"/> 2 -4 X A MONTH <input type="checkbox"/> 2-3x A WEEK <input type="checkbox"/> 4+ TIMES A WEEK	
Have you recently received an influenza vaccine? <input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES, APPROXIMATELY WHEN (month/year)?:
Have you ever received a pneumonia vaccine? <input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES, APPROXIMATELY WHEN (month/year)?:
If you have had a mammogram, please write an approximate date (month/year):	
If you have had a colonoscopy, please write an approximate date (month/year):	
PATIENTS AGED 65+: HAVE YOU HAD ANY FALLS IN THE PAST YEAR? <input type="checkbox"/> No <input type="checkbox"/> One fall with injury <input type="checkbox"/> Two or more falls with injury <input type="checkbox"/> One fall without injury <input type="checkbox"/> Two or more falls without injury	

PLEASE CHECK OFF ANY OF THE FOLLOWING ISSUES YOU'VE HAD OR CURRENTLY HAVE:

SYMPTOMS/ILLNESSES	CONSTITUTIONAL:	<input type="checkbox"/> RECENT WEIGHT CHANGE <input type="checkbox"/> FEVER <input type="checkbox"/> FATIGUE <input type="checkbox"/> HEADACHES
	EYES:	<input type="checkbox"/> EYE DISEASE <input type="checkbox"/> INJURY <input type="checkbox"/> CORRECTIVE LENS <input type="checkbox"/> BLURRED/DOUBLE VISION <input type="checkbox"/> GLAUCOMA
	ENT:	<input type="checkbox"/> HEARING LOSS <input type="checkbox"/> RINGING IN EARS <input type="checkbox"/> EARACHES OR DRAINAGE <input type="checkbox"/> RHINITIS <input type="checkbox"/> NOSEBLEEDS <input type="checkbox"/> MOUTH SORES <input type="checkbox"/> BLEEDING GUMS <input type="checkbox"/> BAD BREATH/TASTE <input type="checkbox"/> SORE THROAT/VOICE CHANGE
	CARDIOVASCULAR:	<input type="checkbox"/> ANGIOPLASTY/BYPASS <input type="checkbox"/> PALPITATIONS/ARRHYTHMIA <input type="checkbox"/> SWELLING OF EXTREMITIES
	GASTRO:	<input type="checkbox"/> BLOOD IN STOOL <input type="checkbox"/> LOSS OF APPETITE <input type="checkbox"/> CHANGE IN BOWEL MOVEMENTS <input type="checkbox"/> NAUSEA/VOMITTING <input type="checkbox"/> HEARTBURN <input type="checkbox"/> ACID REFLUX <input type="checkbox"/> DIARRHEA <input type="checkbox"/> BLOATING <input type="checkbox"/> BELCHING <input type="checkbox"/> ABDOMINAL PAIN <input type="checkbox"/> PEPTIC ULCER
	GENITOURINARY:	<input type="checkbox"/> ERECTILE DYSFUNCTION <input type="checkbox"/> FREQUENT URINATION <input type="checkbox"/> BURNING/PAINFUL URINATION <input type="checkbox"/> BLOOD IN URINE <input type="checkbox"/> INCONTINENCE <input type="checkbox"/> CHANGE IN FORCE OF STREAM <input type="checkbox"/> KIDNEY STONES
	RESPIRATORY:	<input type="checkbox"/> ASTHMA <input type="checkbox"/> SPITTING UP BLOOD <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> WHEEZING
	MUSCULOSKELTAL:	<input type="checkbox"/> DIFFICULTY WALKING <input type="checkbox"/> JOINT PAIN/ STIFFNESS <input type="checkbox"/> JOINT SWELLING <input type="checkbox"/> MUSCLE PAIN/CRAMPS <input type="checkbox"/> BACK PAIN <input type="checkbox"/> DISC DISEASE <input type="checkbox"/> COLD EXTREMITIES
	INTEGUMENTARY:	<input type="checkbox"/> BREAST PAIN, LUMP, DISCHARGE <input type="checkbox"/> RASH/ITCHING <input type="checkbox"/> CHANGE IN SKIN COLOR
	NEUROLOGICAL:	<input type="checkbox"/> STROKE <input type="checkbox"/> FREQUENT HEADACHES <input type="checkbox"/> LIGHTHEADED/DIZZINESS <input type="checkbox"/> SEIZURES <input type="checkbox"/> NUMBNESS/TINGLING <input type="checkbox"/> TREMORS
	PSYCHIATRIC:	<input type="checkbox"/> INSOMNIA <input type="checkbox"/> MEMORY LOSS, CONFUSION <input type="checkbox"/> LOSS OF INTERESTS <input type="checkbox"/> DEPRESSION <input type="checkbox"/> ANXIETY
	ENDOCRINE;	<input type="checkbox"/> HEAT/COLD INTOLERANCE <input type="checkbox"/> HORMONE ISSUES <input type="checkbox"/> THYROID DISEASE <input type="checkbox"/> DIABETES <input type="checkbox"/> EXCESSIVE THIRST
	HEME/LYMPH:	<input type="checkbox"/> PHLEBITIS <input type="checkbox"/> BLOOD TRANSFUSION <input type="checkbox"/> PROLONGED HEALING, BLEEDING, BRUISING <input type="checkbox"/> ANEMIA

PRINT NAME (FIRST, M.I., LAST): _____

MEDICAL HISTORY: PLEASE CHECK OFF YOUR RESPONSES	
DO YOU HAVE LITTLE INTEREST OR PLEASURE IN DOING THINGS?	<input type="checkbox"/> NO <input type="checkbox"/> YES
DO YOU FEEL DOWN, DEPRESSED OR HOPELESS?	<input type="checkbox"/> NO <input type="checkbox"/> YES
OVER THE LAST TWO WEEKS, HOW OFTEN HAVE YOU EXPERIENCED THE FOLLOWING? :	
LITTLE INTEREST/PLEASURE IN DOING THINGS:	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
FEELING DOWN, DEPRESSED, OR HOPELESS:	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
TROUBLE FALLING OR STAYING ASLEEP / SLEEPING TOO MUCH:	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
FEELING TIRED OR HAVING LITTLE ENERGY:	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
POOR APPETITE / OVEREATING:	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
FEELING BAD ABOUT YOURSELF OR THAT YOU'RE A FAILURE, OR HAVE LET YOURSELF OR YOUR FAMILY DOWN:	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
TROUBLE CONCENTRATING ON THINGS, SUCH AS READING THE NEWSPAPER OR WATCHING TV:	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
MOVING OR SPEAKING SO SLOWLY THAT OTHER PEOPLE COULD HAVE NOTICED ; OR THE OPPOSITE, BEING SO FIDGETY OR RESTLESS THAT YOU HAVE BEEN MOVING AROUND A LOT MORE THAN USUAL:	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD, OR OF HURTING YOURSELF IN SOME WAY:	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day