

SHARON E. SELINGER, M.D., F.A.C.P., F.A.C.E.
 DANIEL T. HUBERMAN, M.D., E.C.N.U.
 ARI GELIEBTER, M.D.

One Springfield Avenue, Suite 1A
 Summit, NJ 07901
 Phone: (908) 273-8300
 FAX: (908) 273-8807

GENERAL INFORMATION

Name (Last): _____ First: _____ MI: _____
 Date of Birth: ____/____/____ SS# _____ Referred by: _____
 (Check one) Married Single Domestic Partners Divorced Widowed Separated
 Address: _____ City/State/Zip: _____
 Home Phone: _____ Cell: _____ Work: _____
 Email Address: _____
 Primary Care Physician: _____ Phone: _____
 Primary Care Physician Address: _____
 Employer Name: _____
 Employer Address: _____

RESPONSIBLE PARTY (Complete only if different from patient.)

Name: _____ SS# _____
 Relationship to patient (check one): Spouse Parent Self Domestic Partner
 Home Phone: _____ Cell: _____ Work: _____
 Employer Name: _____
 Employer Address: _____

EMERGENCY CONTACT

Name: _____ Phone: _____
 Address: _____ City/State/Zip: _____
 Relationship to Patient: _____

INSURANCE INFORMATION

Primary Plan Name: _____ Effective Date: ____/____/____
 ID#: _____ Group#: _____
 Policy Holder (if diff. from pt.): _____ SS# _____
 Date of Birth: ____/____/____ Employer: _____
 Secondary Plan Name: _____ Effective Date: ____/____/____
 ID#: _____ Group#: _____
 Policy Holder (if diff. from pt.): _____ SS# _____
 Date of Birth: ____/____/____ Employer: _____

I authorize the release of any medical information necessary to file a claim with my insurance company and authorize payment of insurance benefits directly to the doctor. I also understand that I am financially responsible for payment whether or not covered by insurance.

 Signature of patient or responsible party Printed Name Date

Health History

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PATIENT NAME: _____ DOB: _____/_____/_____

To help us meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history that will be kept in this office. Please use the back of this form if additional space is needed.

Place of birth: _____ Date of last physical exam: _____
 Preferred language: _____ Name of doctor: _____ Phone: _____
 Highest level in school: _____ Date of last dental exam: _____
 Occupation: _____ Smoking (type/amount per day): _____
 Previous occupations: _____ If former smoker, date quit: _____
 Hobbies: _____ Alcohol (type/amount per day): _____
 Exercise/Recreation: _____ Caffeine (type/amount per day): _____
 Usual weight: _____ Street drugs (type/amount per day): _____
 Have you ever taken Fen-Phen/Redux? Yes No Do you have a Living Will or Advance Directive? Yes No

Chief Complaint. Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

Please list all medications you are currently taking (include non-prescription drugs). None

Drug Name	Dose	Frequency

Please list all allergies (foods/drugs/environment). Specify type, location, and severity of reaction. None

Health History (cont.)

Please list all surgeries, serious illnesses, and other hospitalizations (include year occurred).

None

Describe all serious accidents/injuries, head injury, fractures, or broken bones (include date occurred):

None

PAST MEDICAL HISTORY

Have you ever had the following: (Select "No" or "Yes," or leave blank if uncertain.)

	No	Yes		No	Yes		No	Yes
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV+	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Mono	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Blood/Plasma Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Back Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Date of Last Chest X-ray	_____		Any other disease	_____	_____
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>				(Please specify)	_____	_____

FAMILY HISTORY

Please specify if any blood relative has had any of the following: (Select "No" or "Yes," or leave blank if uncertain.)

	No	Yes	Relationship		No	Yes	Relationship
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	For family members, please list present age and good/fair/poor health. If deceased, list cause of death.			
Drug/Alcohol Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	Father	_____		
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mother	_____		
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Siblings	_____		
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Spouse	_____		
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Children	_____		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Financial Policy and Patient Responsibility

SHARON E. SELINGER, M.D., F.A.C.P., F.A.C.E.
DANIEL T. HUBERMAN, M.D., E.C.N.U.
ARI GELIEBTER, M.D.

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We are committed to serving our patients with professionalism and caring, and from our patients, we expect the same commitment. We ask that you be on time for your appointments. We know circumstances can arise preventing you from coming to your appointment. Please call 24 hours in advance to cancel or reschedule. We also ask as part of your financial responsibility that you present your insurance ID at every appointment, make your copays at the time of your office visit, and pay any balance you might owe within 30 days of being billed.

Insurance coverage is an agreement between you and your insurance company. You are responsible for understanding your coverage, benefits, and guidelines. If you find yourself in a difficult financial situation, please call our office to discuss setting up a payment plan. We are here to help.

Please initial each paragraph as an acceptance and understanding of our policies:

- I agree to be financially responsible for payment to Sharon E. Selinger, M.D., P.A. Cash, check, or credit cards are acceptable forms of payment for services.
- I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement. Payments are due within 30 days. Current insurance cards must be presented at every office visit.
- I agree to give my complete and accurate insurance information for primary and secondary insurance benefits. I understand that if I fail to give complete and accurate information about my insurance, this can result in a denial of my claim or delay in payment, and I may be held responsible for the charge.
- I agree that if my insurance plan requires a referral, I will obtain and provide a referral at the time of my visit. If a referral is required and it is not in place at the time of my appointment, my claim may be denied and I will be responsible for the charge.
- If my visit is considered "out of network" by my insurance carrier**, and I have no out-of-network benefit, I will be responsible for payment in full at the time of service.
- I understand that I will be responsible for missed appointments or cancelled appointment charges. I will be charged a cancellation fee of \$50 for appointments cancelled with less than 24-hour notice. A \$50 fee will be charged for any missed or no show appointments. We must charge for these, as the doctors have set aside the time to see you and are unable to schedule other appointments for that time.
- Patients without insurance coverage (self pay) will be expected to pay in full at the time of service.
- Delinquent accounts more than 90 days past due with no payments or broken payment arrangements will be turned over to collections, and an additional charge of \$50 will be added to recoup collection fees.

I agree/authorize to pay for all services rendered in accordance with the terms set forth in this financial policy.

Signature of patient or responsible party

Printed Name

Date

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Acknowledgment of Privacy Practice Notice

I have received a copy of the Sharon E. Selinger, M.D., P.A. Notice of Privacy Practices. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Sharon E. Selinger, M.D., Daniel T. Huberman, M.D., and Ari Geliebter, M.D., for purposes of treatment, payment, or healthcare operations. I understand that my protected health information may be used for such purposes without my written authorization.

Patient's Name

 Birth Date

 Signature of Patient/Parent/Guardian

Today's Date

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

- Home telephone: _____
 - OK to leave message with detailed information
 - Leave message with call back number only
- Work telephone: _____
 - OK to leave message with detailed information
- Cell Phone: _____
 - OK to leave message with detailed information
 - Leave message with call back number only
- Email address we can use to give you electronic access to your medical record: _____
- Written Communication
 - OK to mail to home address
 - OK to mail to work/office
 - OK to fax to: _____
- Leave message with call back number only
- Other: _____

Designation of Certain Relatives, Close Friends, and Other Caregivers

I agree that Sharon E. Selinger, M.D., Daniel T. Huberman, M.D., and Ari Geliebter, M.D. may disclose certain documents regarding my health information to a family member, close personal friend, or other caregiver because such a person is involved with my health care.

I designate the person(s) listed below as individual(s) involved with my health care provided by Sharon E. Selinger, M.D., Daniel T. Huberman, M.D., and Ari Geliebter, M.D. for the purpose of making disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request.

Print Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

 Signature of patient or responsible party

 Printed Name

 Date