Patient Information

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

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

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Health History

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

_____

_____

_____

_____

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	☐	☐	Migraine Headaches	☐	☐	Hives or Eczema	☐	☐
Mumps	☐	☐	Tuberculosis	☐	☐	AIDS or HIV+	☐	☐
Chickenpox	☐	☐	Diabetes	☐	☐	Infectious Mono	☐	☐
Whooping Cough	☐	☐	Cancer	☐	☐	Bronchitis	☐	☐
Scarlet Fever	☐	☐	Polio	☐	☐	Mitral Valve Prolapse	☐	☐
Diphtheria	☐	☐	Glaucoma	☐	☐	Stroke	☐	☐
Smallpox	☐	☐	Hernia	☐	☐	Hepatitis	☐	☐
Pneumonia	☐	☐	Blood/Plasma Transfusions	☐	☐	Ulcer	☐	☐
Rheumatic Fever	☐	☐	Back Trouble	☐	☐	Kidney Disease	☐	☐
Heart Disease	☐	☐	High/Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Arthritis	☐	☐	Hemorrhoids	☐	☐	Bleeding Tendency	☐	☐
Venereal Disease	☐	☐	Asthma	☐	☐	Epilepsy	☐	☐
Anemia	☐	☐	Date of Last Chest X-ray	_____		Any other disease	_____	
Bladder Infections	☐	☐				(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	☐	☐	_____	Stroke	☐	☐	_____
Tuberculosis	☐	☐	_____	Epilepsy	☐	☐	_____
Diabetes	☐	☐	_____	Allergies	☐	☐	_____
Heart Disease	☐	☐	_____	Anemia	☐	☐	_____
High Blood Pressure	☐	☐	_____	Bleeding Tendency	☐	☐	_____
Asthma	☐	☐	_____				
Chronic Lung Disease	☐	☐	_____	For family members, please list present age and			
Drug/Alcohol Problem	☐	☐	_____	good/fair/poor health. If deceased, list cause of death.			
Mental Illness	☐	☐	_____	Father_____			
Leukemia	☐	☐	_____	Mother _____			
Migraine Headaches	☐	☐	_____	Siblings_____			
Obesity	☐	☐	_____	_____			
Thyroid Disease	☐	☐	_____	_____			
Ulcer	☐	☐	_____	_____			
Depression	☐	☐	_____	Spouse_____			
High Cholesterol	☐	☐	_____	Children _____			
Kidney Disease	☐	☐	_____	_____			
Glaucoma	☐	☐	_____	_____			
Gout	☐	☐	_____	_____			

RECENT MEDICAL HISTORY

Do you have now or have you had within the past year: (Select "No" or "Yes," or leave blank if uncertain.)

	No	Yes		No	Yes		No	Yes
Weakness or paralysis	☐	☐	Shortness of breath	☐	☐	Joint pain/stiffness	☐	☐
Tire easily or weakness	☐	☐	Bloody sputum	☐	☐	Swollen joints	☐	☐
Recent weight changes	☐	☐	Wheezing	☐	☐	Muscle cramps/spasms	☐	☐
Change in appetite	☐	☐	Chest pain or discomfort	☐	☐	Sleeplessness	☐	☐
Sensitivity to cold or heat	☐	☐	Purple fingers or lips	☐	☐	Seizures	☐	☐
Persistent fever	☐	☐	Swelling of hands/feet/ankles	☐	☐	Depression	☐	☐
Night sweat or hot flashes	☐	☐	Difficulty breathing	☐	☐	Memory loss	☐	☐
Skin rash	☐	☐	Heart palpitations/fluttering	☐	☐	Poor coordination	☐	☐
Skin trouble or changes	☐	☐	Leg cramps on walking/night	☐	☐	Dizziness/fainting spells	☐	☐
Changes in nails or hair	☐	☐	Enlarged veins	☐	☐			
Headaches	☐	☐	Difficulty swallowing	☐	☐	**Men only:**		
Easy bleeding or bruises	☐	☐	Heartburn	☐	☐	Discharge from penis	☐	☐
Double vision	☐	☐	Frequent belching	☐	☐	Pain or lump in testicles	☐	☐
Blurred vision	☐	☐	Abdominal cramping	☐	☐	Impotence	☐	☐
Eye pain	☐	☐	Nausea	☐	☐			
Infected eyes	☐	☐	Vomiting	☐	☐	**Women only:**		
Wear glasses or contacts	☐	☐	Vomited/coughed-up blood	☐	☐	Age period began		_____
Date of last eye exam		_____	Chronic diarrhea	☐	☐	# of days periods last		_____
Ringing in the ears	☐	☐	Chronic constipation	☐	☐	# of days between periods		_____
Discharge from the ears	☐	☐	Rectal bleeding	☐	☐	Is flow heavy	☐	☐
Ear pain	☐	☐	Black, tarry stools	☐	☐	Do you bleed/spot between	☐	☐
Decrease in hearing	☐	☐	Dark urine	☐	☐	periods		
Frequent nosebleeds	☐	☐	Yellow jaundice	☐	☐	Do you have pain/cramps	☐	☐
Frequent colds	☐	☐	Frequent urination (day)	☐	☐	Date of last period		_____
Sinus trouble	☐	☐	Frequent urination (night)	☐	☐	Date of last pelvic exam		_____
Loss of smell	☐	☐	Increase in thirst	☐	☐	Date of last mammogram		_____
Persistent hoarseness	☐	☐	Painful urination	☐	☐	Any itching in vaginal area	☐	☐
Sore throat	☐	☐	Leakage of urine	☐	☐	Pain with intercourse	☐	☐
Sore tongue or gums	☐	☐	Difficulty in starting urine	☐	☐	Type of birth control used		_____
Lump or discharge from breast	☐	☐	Blood in urine	☐	☐	Number of pregnancies		_____
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐	☐	Lack of sex drive	☐	☐	Number of full-term births		_____
			Hemorrhoids	☐	☐	Number of pre-term births		_____
			Backaches	☐	☐			

The government requires we collect the following information. Please check one box in each category.

Ethnicity:	☐ Hispanic	☐ Non-Hispanic	☐ I prefer not to report.
Race:	☐ Caucasian/European American ☐ African/African American ☐ Asian/Asian American	☐ Native American/ Alaskan ☐ Hawaiian or Pacific Islander ☐ Other	☐ I prefer not to report.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary healthcare services.

_____ _____ _____

Signature of patient or responsible party **Printed Name** **Date**

_____ _____

Physician Signature **Date**

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Financial Policy and Patient Responsibility

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 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

☐ 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:_____

☐ Email address we can use to give you electronic access to your medical record: _____

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**