Pelosi Medical Center

PATIENT INFORMATION UPDATE

Patient Name: _____

Birthdate: ____/_____/____ MR #: _____

(Please print) Today's Date: ____ /___/___

Last Name: First Name: MI:

Preferred: Maiden: Miss/Ms/Mrs/Mr

Birthdate: / / Social Security #: - - Race:

Marital Status: ___Divorced ___Married ___Single ___Widowed ___Separated

Driver's License #:

Primary Language: Religion:

Address:

City: State: Zip code:

Phone Home: ( ) - Primary Work: ( ) - Cell: ( ) -

Employer Name: Employer Address:

Occupation:

Email Address:

Do you have an Advance Directive? ☐ Yes ☐ No If yes, do you have a Proxy Directive? ☐ Yes ☐ No

If yes, name of Proxy (Healthcare Representative): _____

Do you have an Instruction Directive? ☐ Yes ☐ No

VISIT INFORMATION

Why have you come to the office today?

GYNECOLOGIC: ☐_Annual exam _☐_Problem visit If you are here for a problem visit, please explain:

COSMETIC: _☐_ Cosmetic Consultation ___☐ Cosmetic Procedure

How did you hear about us? ☐ Search Engine ☐ Bayonne Community News

☐ El Especialito ☐ Jersey Journal ☐ Other _____

Pelosi Medical Center
350 Kennedy Boulevard
Bayonne, NJ 07002
Tel 201-858-1800 fax 201-858-1002

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA'), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Pelosi Medical Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the Center at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ _____
(Last) (First)

Relationship to Patient: _____

Signature: _____ Date: _____ MR #: _____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices but was unable to do so as documented below:

Reason:
_____
_____
_____

Date: _____ Initials:_____

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of Pelosi Medical Center.

The patient has the right to:

- Be treated with courtesy & respect, with appreciation of his/her individual dignity and with protection of his/her need for privacy.
- Be informed of his/her right to change their provider if other qualified providers are available.
- Be accurately notified of the accreditation status of the facility, reflecting AAAHC as the accrediting entity
- Know that any marketing or advertising regarding the competence and capabilities of the organization is not in any way misleading to the patient.
- Know who is providing medical services and availability of other qualified providers if change is requested.
- Know what patient support services are available, including whether an interpreter is available if he/she does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given, by the health care provider, information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Receive impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental/research and to give his or her consent or refusal to participate in such experimental research.
- Participate in decisions involving their health care, unless contraindicated by concerns for their health.
- Participate in an appropriate assessment and management of pain.
- Refuse treatment, except as otherwise provided by law.
- Be given, upon request, full information & necessary counseling on the availability of known financial resources for his/her care.
- Know, upon request & in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- Be advised prior to care in the event any facility providers do not have Malpractice insurance.
- Express grievances regarding any violation of his or her rights, as stated in applicable state and/or Federal law, through the grievance procedure of the health care provider or health care facility, which served him or her, and to the appropriate state-licensing agency.

A patient is responsible for providing the healthcare team with:

- To the best of his/her knowledge, accurate & complete information about present complaints, past illnesses, hospitalizations, medications, dietary supplements, over-the-counter medications, allergies as well as reactions, & other matters relating to his/her health.
- A complete list of current medications including over-the-counter products & dietary supplements, & any allergies or sensitivities.
- Report of unexpected changes in his or her condition to the health care provider.
- Confirmation to the health care provider whether he/she comprehends a contemplated course of action & what is expected of him/her.
- Full participation with the treatment plan recommended by the health care provider.
- A responsible adult to transport him/her home from the facility and remain with him/her for twenty-four hours (24), if required by his/her provider.
- Punctuality at appointments and when he or she is unable to do so for any reason, notifying the health care facility.
- Accountability for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- Fulfillment of his or her financial obligations for health care provided by the facility as promptly as possible.
- Cooperation in following facility rules and regulations affecting patient care and conduct.
- Information regarding his/her living will, medical power of attorney, or other directive that could affect his/her care.
- Consideration and respect of the facility staff and property
- Any concerns or questions regarding what to expect relative to pain, pain management and other options available.

Filing Complaints

If you have concerns about the care you received at this center, call the facility Medical Director at 201-858-1800.

If you have a complaint against this center, or practitioner contact the Board of Medical Examiners by completing a complaint form that can be retrieved at http://www.state.nj.us/lps/ca/bme/bmeform.htm.

If you are a Medicare recipient and have a complaint against a health care professional or facility you may contact the Office of the Medicare Beneficiary Ombudsman by calling 1-800-MEDICARE or www.medicare.gov

Patient Signature _____ Date _____

Print Name _____ MR # _____

Pelosi Medical Center

PATIENT HISTORY

Patient Name: _____

Birthdate: ___/___/____ MR #: _____

TODAY'S DATE: ___/___/___

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or clinical staff.

PAST MEDICAL HISTORY

MAJOR ILLNESS	DATE	MAJOR ILLNESS	DATE

PAST SURGERIES (INCLUDING COSMETIC SURGERY)

NAME OF OPERATION	DATE	NAME OF OPERATION	DATE

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, and nonprescription medications)

DRUG NAME & DOSE	WHO PRESCRIBED	DRUG NAME & DOSE	WHO PRESCRIBED

ALLERGIES & SENSITIVITIES (FOOD, MEDICATION, & ENVIRONMENTAL)

ALLERGY/SENSITIVITY	TYPE OF REACTION
NO KNOWN ALLERGIES OR SENSITIVITIES ☐	

SMOKING AND ALCOHOL HISTORY

	NEVER	CURRENT	FORMER	AGE STARTED	AGE STOPPED	AMOUNT USED/DAY
SUBSTANCE USE						
ALCOHOL						
TOBACCO						

INFECTION RISK

	EXPOSED TO	POSSIBLY EXPOSED TO:
HEPATITIS B		
HIV		
TUBERCULOSIS		

	YES	NO
HISTORY OF BLOOD TRANSFUSION:		
HISTORY OF SEXUALLY TRANSMITTED DISEASE:		
NO KNOWN INFECTION RISK ☐		

PATIENT SIGNATURE: _____

FORM COMPLETED BY: ☐ PATIENT ☐ OFFICE MED ASST ☐ OTHER