New Jersey Medical Experts, LLC
1740 OAK TREE ROAD
EDISON NJ, 08820
PHONE : 732-494-5000 / 1445
FAX : 732-494-6698

PATIENT INFORMATION – PLEASE ANSWER ALL QUESTIONS COMPLETELY

NAME (LAST, FIRST, MI.):	
DATE OF BIRTH (MM/DD/YYYY):	GENDER : MALE ____ FEMALE ____ RACE: _____ ETHNICITY : _____

MAILING
ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

SOCIAL SECURITY #:	MARITAL STATUS:
HOME PHONE #:	CELL # / OTHER:
EMAIL ADDRESS:	WORK PHONE #:

PHARMACY INFORMATION
NAME OF PHARMACY:_____
ADDRESS_____CITY_____STATE_____ZIP CODE_____
PHONE NUMBER:_____

PRIMARY DOCTOR
NAME: _____ PHONE #: _____
ADDRESS: _____

REFERRING DOCTOR
NAME: _____ PHONE #: _____
ADDRESS: _____

NAME OF PRIMARY INSURANCE_____ SUBSCRIBER NAME: _____ DATE OF BIRTH: _____ SOCIAL SEC. #: _____ RELATIONSHIP: _____	ID #: _____ GROUP #: _____
NAME OF SECONDARY INSURANANCE_____ SUBSCRIBER NAME: _____ DATE OF BIRTH: _____ SOCIAL SEC. #: _____ RELATIONSHIP: _____	ID #: _____ GROUP #: _____
NAME OF TERTIARY INSURANCE_____ SUBSCRIBER NAME: _____ DATE OF BIRTH: _____ SOCIAL SEC. #: _____ RELATIONSHIP: _____	ID #: _____ GROUP #: _____

EMERGENCY CONTACT INFO.
NAME: _____ RELATIONSHIP: _____
PHONE #: _____

I request that payment of authorized medicare benefits be made either to me or on my behalf to the Primary Physician or Supplier for any services furnished me by the Primary Physician or Supplier. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT SIGNATURE _____ **DATE** _____

HIPAA NOTICE OF PRIVACY PRACTICES

New Jersey Medical Experts, LLC
1740 OAK TREE ROAD
EDISON NJ, 08820
PHONE: 732-494-5000 /1445
FAX: 732-494-6698

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "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.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment : We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that you relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready t see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

HIPAA NOTICE OF PRIVACY PRACTICES

New Jersey Medical Experts, LLC
1740 OAK TREE ROAD
EDISON NJ, 08820
PHONE: 732-494-5000 /1445
FAX: 732-494-6698

(Page 2; continued from Page 1)

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

(Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.)

Print Name _____
Signature _____
Date _____

New Jersey Medical Experts, LLC
1740 OAK TREE ROAD
EDISON NJ, 08820
PHONE: 732-494-5000 /1445
FAX: 732-494-6698

HEALTH HISTORY

Patient Name _____ **Date of Birth** _____

To help us meet all your healthcare needs, please fill out both sides of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's Date _____ When was your last physical exam? _____
Place of Birth _____ Name of Doctor _____ Phone # _____
Highest level in school _____ Date of last Dental Exam _____
Occupation _____ Previous Occupation _____
Hobbies _____ Exercise/Recreation _____

Habits: Smoking (Type & Amount) _____ Start date _____ Quit Date _____
Alcohol (Type & Amount) _____ Start date _____ Quit Date _____
Caffeine (Type & Amount) _____ Your Casual Weight _____

Please list all allergies (Food, Drug, and Environment)
_____

Please list all serious illness, surgeries, operations, accidents, and other hospitalization you have experienced & indicate the years they occurred.
_____
_____
_____

Please list all medications you are currently taking (Including non prescription drugs)
_____
_____
_____

Chief Complaints - Please list the present health concern, symptoms, or problems you are experiencing.
_____

Past Medical History - Have you ever had any of the following? (Circle "Yes" or "No", leave blank if uncertain)

Measles	Yes	No	Asthma	Yes	No
Hives or Eczema	Yes	No	Migraine headaches	Yes	No
Tuberculosis	Yes	No	Mumps	Yes	No
Chickenpox	Yes	No	AIDS or HIV+	Yes	No
Whooping cough	Yes	No	Diabetes	Yes	No
Bronchitis	Yes	No	Cancer	Yes	No
Fever	Yes	No	Infectious Mono	Yes	No
Mitral Valve prolapse	Yes	No	Polio	Yes	No
Glaucoma	Yes	No	Diphtheria	Yes	No
Smallpox	Yes	No	Stroke	Yes	No
Pneumonia	Yes	No	Hernia	Yes	No
Rheumatic fever	Yes	No	Blood/Plasma Transfusion	Yes	No
Heart Disease	Yes	No	Ulcer	Yes	No
Arthritis	Yes	No	Kidney Disease	Yes	No
High or Low B/P	Yes	No	Backache	Yes	No
Anemia	Yes	No	Thyroid Disease	Yes	No
Bladder Infection	Yes	No	Hemorrhoids	Yes	No
Bleeding Tendency	Yes	No	Other _____		

Family Medical History

			Relationship
Cancer	Yes	No	_____
Tuberculosis	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Hypertension	Yes	No	_____
Stroke	Yes	No	_____
Epilepsy	Yes	No	_____
Allergies	Yes	No	_____
Anemia	Yes	No	_____
Asthma	Yes	No	_____
Chronic Lung disease	Yes	No	_____
Drugs/Alcohol	Yes	No	_____
Mental Illness	Yes	No	_____
Leukemia	Yes	No	_____
Migraine	Yes	No	_____
Obesity	Yes	No	_____
Thyroid Disease	Yes	No	_____
Ulcer	Yes	No	_____
Depression	Yes	No	_____
High Cholesterol	Yes	No	_____
Kidney Disease	Yes	No	_____
Glaucoma	Yes	No	_____
Gout	Yes	No	_____

Present age and health. If deceased, cause of death.

Father _____
Mother _____
Siblings _____
_____
_____
_____
Spouse _____
Children _____
_____
_____
_____

Additional Comments:

_____
_____
_____
_____
_____

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

Weakness or paralysis	Yes	No	Frequent Urination	Yes	No
Joint pain or stiffness	Yes	No	Painful Urination	Yes	No
Swollen joints	Yes	No	Blood in Urine	Yes	No
Muscle cramps/ spasm	Yes	No	Lack of sex drive	Yes	No
Sensitivity cold/hot	Yes	No	Hemorrhoids	Yes	No
Fever	Yes	No	Backache	Yes	No
Skin rash	Yes	No	Shortness of Breath	Yes	No
Ear pain	Yes	No	Constipation	Yes	No
Vomiting	Yes	No	Palpitation	Yes	No
Blurred vision	Yes	No	Bloody Sputum	Yes	No
Chronic diarrhea	Yes	No	Wheezing	Yes	No
Dark Urine	Yes	No	Chest pain	Yes	No
Sinus trouble	Yes	No	Sleeplessness	Yes	No
Seizures	Yes	No	Depression	Yes	No
Heartburn	Yes	No	Nausea	Yes	No
Memory Loss	Yes	No	Dizziness	Yes	No
Rectal bleeding	Yes	No	Sore throat	Yes	No

Men Only

Discharge from penis	Yes	No
Pain or lump in testicles	Yes	No
Impotence	Yes	No

Women Only

Age period began _____ Heavy Flow Yes No
Duration of period _____ Cramps Yes No
Days between periods _____ Itching Yes No
Date of last period _____ Date of pelvic exam _____
Date of last mammogram _____ Current birth control _____
Number of full term births _____ Number of total pregnancies _____

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 my (my child'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 health care services I (my child) may need.

Signature of Patient _____ **Date** _____