



JOANN GUALBERTI, MD, FACP
LISA GUALBERTI, MD, FACP
FELLOWS, AMERICAN BOARD OF
INTERNAL MEDICINE, & HOSPICE
& PALLIATIVE MEDICINE

Pursuing Wellness With Care

9 Professional Circle • Suite 101 • Fairways Professional Plaza • Colts Neck, NJ 07722
Phone: (732) 431-1520 • Fax: (732) 431-1567

Patient Name: _____
D.O.B. _____ Male () Female () Marital Status: _____
Address: _____ City, State, Zip: _____
Race: White () African American () Asian () Other: _____
Ethnicity: Hispanic () Non-Hispanic () Language: English () Other: _____
Home Phone: _____ Cell Phone: _____
Retail Pharmacy: _____ Address/Phone: _____
Email Address: _____
Emergency Contact Name: _____ Phone: _____

Primary Insurance Information

Insurance Plan: _____ ID #: _____
Policy Holder: _____ D.O.B: _____
Male () Female () Relationship to Patient: _____
Address (if different than patient): _____

Secondary Insurance Information

Insurance Plan: _____ ID #: _____
Policy Holder: _____ D.O.B: _____
Male () Female () Relationship to Patient: _____
Address (if different than patient): _____

PRIVACY PRACTICES

I acknowledge that I understand and comply with Orchard Medical Group's Notice of Privacy Practices. I consent that Orchard Medical Group can request and use my prescription medication history from other Healthcare Providers and/or third party pharmacies for accurate treatment purposes. I certify that all the given medical and demographic information is accurate to the best of my knowledge.

Sign _____ Date _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Orchard Medical Group for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance including co-payments, co-insurance and deductibles. I further authorize Orchard Medical Group to release any information required to secure payment benefits. I authorize signature of all insurance claim submissions,

Sign _____ Date _____

Patient Name: _____

PATIENT MEDICAL HISTORY

What are you here for today? _____

Please check any illnesses that you have been treated for (Items not checked are understood to be negative):

- | | | |
|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Deep Vein Phlebitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Progressive Neurological Disorder |
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> AFIB | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Vitamin D Deficiency |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Vitamin __ Deficiency |
| <input type="checkbox"/> Auto-Immune Illness | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hypothyroidism | Other: _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Coronary Artery Disease (CAD) | <input type="checkbox"/> Liver Disease | |

ALLERGIES

DO YOU HAVE ANY DRUG ALLERGIES? NO YES (if yes, please list below)

DRUG(S): _____

DO YOU HAVE ANY ENVIRONMENTAL ALLERGIES? NO YES (if yes, please list below)

DO YOU HAVE ANY FOOD ALLERGIES? NO YES (if yes, please list below)

FOOD(S): _____

IMMUNIZATIONS

VACCINE NAME

DATE

Patient Name: _____

FAMILY HISTORY

Circle **M** for Mother - **F** for Father - **S** for Sibling - **MS** for Maternal Side – **PS** for Paternal Side

<input type="checkbox"/> Heart Disease	M	F	S	MS	PS	Alive	M	F	S	MS	PS
<input type="checkbox"/> Diabetes	M	F	S	MS	PS	Deceased	M	F	S	MS	PS
<input type="checkbox"/> Hypertension	M	F	S	MS	PS	Unknown	M	F	S	MS	PS
<input type="checkbox"/> Cancer: _____	M	F	S	MS	PS						
<input type="checkbox"/> Stroke	M	F	S	MS	PS						
<input type="checkbox"/> Renal Disease	M	F	S	MS	PS						
<input type="checkbox"/> Alcoholism	M	F	S	MS	PS						
<input type="checkbox"/> Thyroid Disease	M	F	S	MS	PS						
<input type="checkbox"/> Other: _____						M	F	S	MS	PS	

SOCIAL

Do you smoke tobacco? Currently Smokes Former Smoker Never Smoker Unknown

Marital Status: Married Single Divorced Widowed

Number of Children: _____

Employment: Employed Unemployed Retired Student

Do you currently drink alcohol? Never Socially drinks Drinks daily ____ per day

Have you ever used illegal drugs? Never Currently Quit less than 3 years ago In the past only

MEDICATIONS

List all medications with dose, to include: Prescription, Over-the-Counter, Herbal, Nutritional Supplements:

Med:_____	Dose:_____	Med:_____	Dose:_____
Med:_____	Dose:_____	Med:_____	Dose:_____
Med:_____	Dose:_____	Med:_____	Dose:_____
Med:_____	Dose:_____	Med:_____	Dose:_____

SURGICAL HISTORY

Surgery	Date	Surgery	Date
_____	_____	_____	_____
Surgery	Date	Surgery	Date
_____	_____	_____	_____

Patient Name: _____

FEMALE PATIENTS

LAST MENSTRUAL PERIOD: _____

NORMAL MENSES? Y OR N

DURATION OF THE MENSTRUAL CYCLE: _____

DUARTION OF THE MENSTRUAL PERIOD: _____

ON BIRTH CONTROL PILLS: Y OR N

BIRTH CONTROL METHOD: _____

MENAPAUSE: Y OR N DATE: _____

PERIMENOPAUSE: Y OR N

POST MENOPAUSE: Y OR N

NUMBER OF ALL PREGNANCIES: _____ NUMBER OF BIRTHS _____

HEALTH MAINTENANCE

WHEN WAS YOUR LAST:	<u>DATE</u>	<u>N/A</u>
BONE DENSITY	_____	_____
COLONOSCOPY	_____	_____
DENTAL EXAM	_____	_____
MAMMOGRAM	_____	_____
OPHTHALMOLOGY	_____	_____
PAP	_____	_____
PSA	_____	_____
SKIN CANCER SCREENING	_____	_____

Patient Name: _____

REVIEW OF SYSTEMS (Items not checked are understood to be negative)

CONSTITUTIONAL

- Chill
- Fatigue
- Fever
- Malaise
- Weight Gain
- Weight Loss

- Myalgias
- Arthralgias
- Muscle Weakness
- Joint Swelling
- Joint Erythema
- Joint Warmth
- Stiffness

EYES

- Visual Disturbances

DERM

- Rash
- Pigmentation Change
- New Lesions
- Pruritus/Itchy Skin

E/N/T

- Dizziness
- Nasal Congestion
- Nasal Drainage
- Sore Throat
- Facial Pain
- Ear Plugging
- Ear Discharge
- Postnasal Drip
- Change in Smell
- Change in Taste

NEURO

- Headache
- Dizziness
- Weakness
- Numbness
- Confusion
- Paralysis
- Syncope/Loss of Consciousness

CARDIO

- Chest Pain
- Palpitations
- Syncope
- Edema
- Shortness of Breath on exertion

PSYCH

- Anxiety
- Depression
- Insomnia
- Suicidal Ideation
- Suicidal Planning

RESPIRATORY

- Cough
- Shortness of Breath
- Wheezing

ENDOCRINE

- Cold Intolerance
- Heat Intolerance
- Polydipsia/Excessive Thirst
- Polyuria/Frequent Urination
- Sexual Dysfunction
- Change in Libido

GASTROINTESTINAL

- Abdominal Pain
- Constipation
- Diarrhea
- Nausea
- Rectal Bleeding
- Vomiting

HEMATOLOGIC/LYMPHATIC

- Easy Bruising
- Easy Bleeding
- Night Sweats
- Swollen glands

GENITOURINARY/NEPHROLOGY

- Change in Urine Color
- Dysuria/Difficulty Urinating

ALLERGY/IMMUNOLOGY

- Sneezing
- Eye Itching
- Nasal Itching
- Oral/Mouth Swelling

MUSCULOSKELETAL

- Back Pain



JOANN GUALBERTI, MD, FACP
LISA GUALBERTI, MD, FACP
FELLOWS, AMERICAN BOARD OF
INTERNAL MEDICINE, & HOSPICE
& PALLIATIVE MEDICINE

Pursuing Wellness With Care

9 Professional Circle • Suite 101 • Fairways Professional Plaza • Colts Neck, NJ 07722
Phone: (732) 431-1520 • Fax: (732) 431-1567

PATIENT RESPONSIBILITY

- This office participates in many insurance plans. It is your responsibility to contact your insurance carrier to inquire if you are entitled to preventive medicine services, (i.e. screening blood work and annual physical exams). It is also your responsibility to know if your insurance requires referrals and/or authorizations for scheduled procedures or specialists appointments. These procedures may include but are not limited to sonograms, radiology services, laboratory services, hospital testing, surgical procedures, hospital admissions, as we as many testing done in this office.
- Please give the office 3-5 business days for any referrals and/or authorizations. Although we realize there are emergency situations we asked that you don't repeatedly call for same day referrals as this disrupts the flow of the office and may result in you having to cancel your appointment.
- We give careful time and attention to every patient that comes in and fill our schedule accordingly. We ask that you take this into consideration when cancelling your appointment on short notice. We ask for, when possible, 24 hour notice for all cancellations or you will be charged a \$50.00 fee for all cancelled physicals and \$35.00 for all other appointments.

Thank you for your consideration

Print Patient's Name

Patient's Signature

Date