ORCHARD
MEDICAL GROUP

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):

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

Other: _____
_____

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

□ Heart Disease	M	F	S	MS	PS	Alive	M	F	S	MS	PS
□ Diabetes	M	F	S	MS	PS	Deceased	M	F	S	MS	PS
□ Hypertension	M	F	S	MS	PS	Unknown	M	F	S	MS	PS
□ Cancer: _____	M	F	S	MS	PS						
□ Stroke	M	F	S	MS	PS						
□ Renal Disease	M	F	S	MS	PS						
□ Alcoholism	M	F	S	MS	PS						
□ Thyroid Disease	M	F	S	MS	PS						
□ 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: _____

MENAUPASE: 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:	DATE	N/A
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

EYES
- ☐ Visual Disturbances

E/N/T
- ☐ Dizziness
- ☐ Nasal Congestion
- ☐ Nasal Drainage
- ☐ Sore Throat
- ☐ Facial Pain
- ☐ Ear Plugging
- ☐ Ear Discharge
- ☐ Postnasal Drip
- ☐ Change in Smell
- ☐ Change in Taste

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

RESPIRATORY
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

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

GENITOURINARY/NEPHROLOGY
- ☐ Change in Urine Color
- ☐ Dysuria/Difficulty Urinating

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Myalgias
- ☐ Arthralgias
- ☐ Muscle Weakness
- ☐ Joint Swelling
- ☐ Joint Erythema
- ☐ Joint Warmth
- ☐ Stiffness

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

NEURO
- ☐ Headache
- ☐ Dizziness
- ☐ Weakness
- ☐ Numbness
- ☐ Confusion
- ☐ Parenthesis
- ☐ Syncope/Loss of Conciseness

PSYCH
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Suicidal Ideation
- ☐ Suicidal Planning

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

HEMATOLOGIC/LYMPHATIC
- Easy Bruising
- Easy Bleeding
- Night Sweats
- Swollen glands

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

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HIPAA AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

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:

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

I give my permission for this office (Orchard Medical Group) to leave messages on my home and/or cell phone voicemail. ***(Circle One - Home / Cell)***

_____	_____	_____
Print Patient's Name	**Patient's Signature**	**Date**

I make the following special request of confidential communications: The people whom, in addition to myself, may be given this confidential information are:

Name	**Relationship to Patient**	**Telephone**
_____	_____	_____
_____	_____	_____

Health Information Exchange (HIE) - We, along with other health care providers in New Jersey, participate in Jersey Health Connect, a health information exchange ("HIE") which allows patient information to be shared electronically through a secured network that is accessible to the providers treating you. We may disclose your medical information to Jersey Health Connect HIE, unless you opt-out (by signing an additional form) of participating in the HIE.

_____	_____	_____
Print Patient's Name	**Patient's Signature**	**Date**

Personal Health Record (PHR) – Certain portions of your medical record are available electronically to you in a PHR which is accessible at MyMeridianHealth.com. Enrollment is required. We may disclose your medical information to the Jersey health Connect HIE for purposes of adding your medical information to your Personal Health Records (PHR).

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 this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to 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.

_____	_____	_____
Print Patient's Name	**Patient's Signature**	**Date**

This form expires exactly 1 year from the date signed.

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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**