

ENDO-SURGICAL ASSOCIATES

Patient Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ Work Phone: (____) _____
Cell Phone: (____) _____ Sex: Male _____ Female _____
Date of Birth: _____ Age: _____ Social Security #: _____
Employer Name: _____ Occupation: _____
Work Address: _____
Emergency Contact: _____ Telephone #: _____
Relationship of Emergency Contact to Patient: _____
Insurance Carrier: _____
Insurance Address: _____
Insurance Phone: (____) _____ Effective Date: _____
Insured: _____ Insured's Date of Birth: _____
ID #: _____ Group: _____ Copay: _____
Name of Spouse: _____ Referral: _____ Yes _____ No _____
Secondary Coverage: _____
Secondary Insurance ID #: _____ Group: _____
Primary Doctor: _____ Phone: (____) _____
Address: _____
Other Doctors: _____

I request and authorize payment of benefits to be made on my behalf directly to **Endo-Surgical Associates** for services provided to me by **Endo-Surgical Associates**. I also authorize any holder of medical information about me to release to insurance carriers, government agencies or others who are financially liable for my medical care any information needed to determine these benefits and the benefits payable for related services

Signature of Patient or Representative

Date

Name: _____ Social Security Number: _____

Referring Doctor: _____ Age: _____ Date: _____

Reason for Current Visit

Are you **Allergic or sensitive** to any medication or any radiographic dye? (list medication and reaction)

I have no allergies _____

List all your **current medications** and dosages including supplements. (example: Lipitor 10 mg daily, Saw Palmetto Herbs)

I take no medications _____

Past Medical & Surgical History

List all illnesses

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Irregular Rhythm |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastritis/Ulcer |
| <input type="checkbox"/> Cancer (List) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Urine Infections |
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Kidney Cancer |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> I HAVE NO MEDICAL |
| <input type="checkbox"/> Phlebitis | PROBLEMS |
| <input type="checkbox"/> High Cholesterol | |

List all your operations (include dates) (example: hernia repair 1991 etc.)

I have had no surgery _____

Advance Benefeciary Notice

In the even that I lose my health insurance benefits and become a self-paying patient. I acknowledge and understand that I am responsible for of all medical services rendered tome by the physicians of Endo-Surgical Associates of Central Jersey, LLC, as well as for any unpaid cash balances to my account.

Patient

Signature of Patient/Guarantor

Date

Office of Endo-Surgical Associates of Central Jersey LLC

Introduction to Privacy Notice

Dear Patient,

This is a summary of the ways in which medical information about you may be used and disclosed, and how you can get access to this information. Endo-Surgical Associates of Central Jersey, LLC., their associates, and entire staff will use your medical information as part of rendering patient care. Your medical information may be used for treatment, payment, or healthcare operations. For example, your medical information maybe used by the healthcare professional treating you, by the office insurance coordinator to process your payment for the services rendered, and by administrative personnel reviewing the quality and appropriateness of the care you receive. Your information may also be disclosed pursuant to applicable federal and state law.

The complete Notice of Privacy Practices is located in the waiting area. We encourage that you read the entire Notice. Additionally, you are required to acknowledge in writing that you have received a copy of the Consent for Release of Information form that is attached.

The attached Notice is effective as of April 14, 2003

THIS IS A NEW FORM THAT IS NESCESSARY TO BE PART OF YOUR MEDICAL CHART MANDATED BY THE GOVERNMENT. IT ASSURES YOU THAT I WILL TRY TO PROTECT YOUR MEDICAL PRIVACY. IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO CALL.

Endo-Surgical Associates of Central Jersey LLC

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT,
PAYMENT, AND HEALTH CARE OPERATIONS

I, _____ hereby authorize **Endo-Surgical Associates of Central Jersey, LLC** to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **Endo-Surgical Associates of Central Jersey, LLC** can refuse to treat me.

I have been informed that **Endo Surgical Associates of Central Jersey, LLC** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations, I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **Endo-Surgical Associates of Central Jersey, LLC** in writing, but if I revoke my consent, such revocation will not affect any actions that **Endo-Surgical Associates of Central Jersey, LLC** took before receiving my revocation.

I understand that **Endo-Surgical Associates of Central Jersey, LLC** has reserved the right to change his/her practices and that I can obtain such change notice upon request.

I understand that I have the right to request that **Endo-Surgical Associates of Central Jersey, LLC** restricts how my individual identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that **Endo-Surgical Associates of Central Jersey, LLC** does not have to agree to such restrictions, but that once restrictions are agreed to, **Endo-Surgical Associates of Central Jersey, LLC** must adhere to such restrictions.

Signature of patient or patient's representative
(Form must be completed before signing)

Date

Printed name of patient or representative

Relationship to the patient