Maria Choy, M.D.
Director
EMG, Acupuncture
Board Certified Neurologist

Central Jersey Neurological Institute, PA

Welcome to Our Office

NEW PATIENT INFORMATION Date _____

PATIENT NAME (PRINT)	SOCIAL SECURITY #	MARITAL STATUS	GENDER	RELIGION
ADDRESS	CITY	STATE ZIP CODE	BIRTH DATE	AGE
PATIENT OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	HOME PHONE	CELL PHONE
EMPLOYER ADDRESS	CITY	STATE, ZIP CODE	BUSINESS PHONE	HOW LONG EMPLOYED
DRUG ALLERGIES				
SPOUSE OR PARENT	SOCIAL SECURITY #	BIRTH DATE	CELL PHONE	HOME PHONE
SPOUSE/PARENT EMPLOYER	EMPLOYER ADDRESS	CITY	STATE ZIP CODE	BUSINESS PHONE

HIPAA GOVERNMENT REQUIREMENT FOR MEDICAL RECORDS

RACE (circle): Asian Black Caucasian Other Declined

Ethnicity (Circle): Hispanic Non-hispanic Declined

Language (Circle): English Spanish Other

Tobacco use (circle):

Never Smoked Non-smoker Smoker How many Packs per day? _____

Alcohol use: None, Occasional or # glasses/shots _____ per day or week

ALL PROFESSIONAL SEVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WIL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____ HIC Number _____
Request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to _____ for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration or other intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to name the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128B of Social Security Act and 31 USC 3801-8 provides penalties for withholding this information)

Signature _____ Date _____

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Patient _____DOB _____
Today's Date _____

BP _____ Pulse _____ Wt _____ Ht _____

Referring MD _____
Referring MD Address, phone #, and Fax # _____
Primary Care Doctor Address, Phone #, Fax # _____
REASON FOR VISIT _____
LOCATION _____ QUALITY _____
(WHERE IS PAIN/PROBLEM) (EX: SHARP, DULL, TINGLING)
SEVERITY _____ DURATION _____
(HOW BAD IS PAIN/PROBLEM) (HOW LONG HAVE YOU HAD PROBLEM/WHEN DID IT START)
TIMING _____ CONTEXT _____
(Does pain problem occur at specific time) (Where were you at start of problem)
WHAT ASSOCIATED PROBLEMS HAVE YOU BEEN HAVING? _____
WHAT MAKES PROBLEM WORSE/BETTER? _____
HAS THIS HAPPENED BEFORE? _____

FOR PRE-CERTIFICATION NEEDS:
Medications tried for this problem before, including over the counter meds. For how long?
_____
Physical Therapy tried? How long? _____
Chiropractor? How long? _____

PAST MEDICAL HISTORY (Please circle):

Diabetes	Hypertension	Arthritis	Cancer (type)
Stroke	Heart trouble	Gout	Convulsions
Bleeding tendency	Acute infections	Venereal disease	HIV positive
Hepatitis	Transfusions	Hereditary defects	Asthma

PREVIOUS HOSPITALIZATIONS OR SURGERIES
_____
_____

SOCIAL HISTORY (Circle)

Marital status: Single	Married	Separated	Divorced	Widowed	Significant other
Use of Alcohol: Never	Rarely	Moderate	Daily		
Use of Tobacco: Never		Previously but quit		Current packs/day ____	
Use of drugs: Never	Type/frequency _____				
Industrial exposure to:	Dust	Solvents		Fumes	

FAMILY HISTORY:	Age	Diseases	If deceased, cause and age
MOTHER			
FATHER			
SIBLINGS			

470 Highway 79 Suite 5 ~ Morganville, N.J. 07751~ (732)591-5888 ~ Fax (732)591-1133
The above has been reviewed by Doctor _____

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Patient _____

DOB _____ Today's Date _____

BP _____ Pulse _____ Wt _____ Ht _____

REVIEW OF SYSTEMS (circle or write in if relevant)

General: Fever, Chills, Night sweats, Recent Weight Change, Appetite, Fatigue, Headaches No symptoms	**Musculoskeletal:** Joint Pain, joint, stiffness, Joint Swelling, Muscle Aches, weakness of muscles or joints, muscle pain, cramps, back pain, cold extremities, difficulties walking, neck pain No symptoms
Eyes: Wears glasses, eye injury, Change in Vision, Pain, Double Vision, Glaucoma, blurry vision No symptoms	**Skin:** Rashes, itching, change in skin color, change in hair or nails, Varicose veins No symptoms
Ears, nose, throat: Ear Pain, EarDischarge, Decreased Hearing, Ringing in the ears, hearing loss, nose bleeds, nasal discharge, sinus pain, Mouth Sores, Bad breath, Bleeding gums, Sore throat, swollen glands No symptoms	**Neuro:** Recurrent headaches, lightheaded or dizzy, convulsions or seizures, numbness or tingling, Tremors, Paralysis, Stroke, Transient Loss of Speech, or Vision, Memory Loss, Head injury No symptoms
Breasts: Lumps, Pain, Discharge No symptoms	**Psychiatric:** Memory loss or confusion**,** Anxiety, Nervousness, Depression, Sadness, Irritability No symptoms
Cardiovascular: Heart trouble, Chest Discomfort, Palpitations, short of breath walking, short of breath lying flat, swelling of feet or hands , heart murmur No symptoms	**Endocrine:** Gland problem, hormone problem, Thyroid disease, diabetes, excessive thirst or urination, heat or cold intolerance, dry skin, change in hat or glove size. No symptoms
Respiratory: Cough, Wheezing, Sputum, coughing blood, short of breath walking, short of breath lying flat, Chest Pain when breathing, Snoring, Daytime sleepiness, asthma, wheezing No symptoms	**Hematology:** Slow to heal after cuts, bleeding or bruising tendency, anemia, Phlebitis, Past transfusion, Enlarged glands, HIV positive. No symptoms
Gastrointestinal: Trouble Swallowing, Heartburn, vomiting blood, Nausea, Vomiting, Pain, Swelling of abdomen, Constipation, Diarrhea, blood in stool, Hemorrhoids, Fecal Incontinence, Jaundice, peptic ulcer No symptoms	**Allergy:** Reaction to Penicillin or other antibiotic, Morphine, Demerol or narcotics Novocaine or other anesthetics Aspirin or other pain remedies Tetanus or other vaccines NONE
Genitourinary: Frequent urination, Burningor Pain with urination, blood in urine, change in force of stream, Dribbling, Incontinence, Incomplete Emptying, Night time urination, Sexual Dysfunction, testicular pain No symptoms	**Allergy:** Iodine, fish, shell fish Antiseptics Food allergies NONE
Gyn: # pregnancies ___, # miscarriages ___, Last Menstrual period ____, Excess Bleeding, Irregular Bleeding, Painful periods, Hot Flashes, Postmenopausal Bleeding No symptoms	**ANYTHING ELSE WE NEED TO KNOW ABOUT YOU:**

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NAME _____ BIRTHDATE _____ TODAY'S DATE _____

LIST ALL MEDICATIONS HOME PHONE _____ CELL PHONE _____

INCLUDING OVER THE COUNTER MEDICATIONS, SUPPLEMENTS, VITAMINS AND HOMEOPATHICS

DATE	DRUG	DOSE	DR PRESCRIBING

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Patient Name _____

INDIVIDUAL PATIENT'S AUTHORIZATION

1. INVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily:

Individual Patient's Name: _____

Your Address: _____

Your Telephone number: _Home _____Cell_____Fax_____

Your e-mail Address _____

2. (Please initial) THE USE AND/OR DISCLOSURE AUTHORIZED

____ The protected health information you are authorizing to be used and/or disclosed for billing and medical records purposes and coordination of medical care.

_____You are authorizing Central Jersey Neurological Institute and Dr. Maria Choy to use and/or disclose the protected health information described above

_____You are authorizing Central Jersey Neurological Institute and Dr. Maria Choy to leave messages on your answering machine, fax machine, or e-mail as above

_____Name the people and/or organizations (or kinds of people and/or organizations) that you are authorizing to receive and use your protected health information (***please circle and initial, add names as needed)*:** _____**INSURANCE COMPANIES, _____ PRE-CERTIFICATIONS TO INSURANCE COMPANIES _____OTHER HEALTH CARE PROVIDERS INVOLVED IN YOUR CARE , _____ SPOUSE, _____CHILDREN, _____PARENT**

_____
_____
_____

_____

You are authorizing your protected health information to be used and/or disclosed for purposes of billing and medical records , coordination of medical care, and educating family and caretakers

Choose one and INITIAL one: ENDING AUTHORIZATION

___ This authorization is indefinite

___ This authorization will end on the following date _____

___ This authorization will end when the following event happens. The event must relate to the individual or the purpose of authorized use and/or disclosure. Describe event below: _____

INDIVIDUAL PATIENT'S AUTHORIZATION

Central Jersey Neurological Institute, PA

Maria Choy, M.D.
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Patient Name _____

3. **CHANGING YOUR MIND ABOUT THIS AUTHORIZATION**
I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer in your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and if I revoke this authorization, the insurance company has the right to contest my claims under the insurance policy.

4. SIGNING THE AUTHORIZATION IS NOT A CONDITION OF TREATMENT
I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing this authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the plan to make enrollment and eligibility determinations.

5. INDIVIDUAL PATIENT'S SIGNATURE
I have had the chance to read and think about the content of this authorization form and agree with all the statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature _____Date _____

If this authorization is signed by a personal representative for the individual patient:

Personal Representative's Name _____
(Print name)

_____
(Signature)

Relationship to individual _____

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PRESCRIPTION AUTHORIZATION

I authorize Central Jersey Neurological Institute, LLC, Maria Choy MD, and their representatives to send electronic prescriptions and receive electronic pharmacy history:

Local Pharmacy Name, Address and Phone _____

_____

Mail Away Pharmacy Name, Address, Contact info and Phone Number:

_____

_____

Signature _____ Date Signed _____

Patient Full Name: _____ Date of birth _____

Patient Full Address:

_____

_____

AUTHORIZATION TO LEAVE MESSAGES ON TELEPHONE OR ELECTRONIC DEVICE:

Telephone(s) _____

E-mail address (s) _____

Other method of contact _____

Signature _____ Date Signed _____

Patient Full Name: _____