JERSEY SHORE GERIATRICS

Dear New Patient:

Welcome to Jersey Shore Geriatrics. Thank you for choosing this practice to assist you in your health care needs.

Jersey Shore Geriatrics is not a traditional medical practice.

- Our staff of doctors and nurse practitioners visit 30 other facilities (assisted living, independent living and rehabilitation centers and nursing homes) during the week.
- Dr. Pass is in the Lakewood office on Mondays and the Marlboro office on Thursdays - 9 am to 5 pm
- We have a nurse practitioner in the Lakewood office on Wednesdays and Fridays - 9 am to 5 pm

Our office in Marlboro is open from 9 am to 5 pm, Monday through Friday to assist you and to help with your medical issues. Our office in Lakewood is also open from 9 am to 5 pm, Monday, Wednesday and Friday to assist you and to help with your medical issues. You can reach a doctor or nurse practitioner 24 hours a day, 7 days a week if there is an emergency, by calling us. Dr. Pass is affiliated with Jersey Shore University Medical Center.

In our efforts to give you the best possible geriatric care we ask that you fill out the enclosed forms and return it to us prior to your first appointment. This will assist the doctor in evaluating and treating your medical conditions. We also ask that you send us a copy of your Medicare and other insurance cards. In addition, we ask that you have all of your prescription and over-the-counter medication, including vitamins, with you. Lastly, if you have any of the following documents: Living Will and/or Advanced Directive or Power of Attorney, have them available so we can make copies to complete our files.

We appreciate your assistance with this process. We look forward to helping you with your most important assets, your health and well-being. Should you have any questions or concerns, please do not hesitate to contact us at 732-866-9922.

Jersey Shore Geriatrics
15 School Road East Suite #2
Marlboro, New Jersey 07746
Email: jsglabs@gmail.com
Phone – 732-866-9922 Fax – 732-866-9970
www.jerseyshoregeriatrics.com

PATIENT INTAKE FORM

Name: _____ Date of Birth: _____
(first) (last) Age: _____ Sex: M ☐ F ☐

Home Address: _____
Street Address Apt # City State Zip Code

Billing Address: _____
Street Address Apt # City State Zip Code

Telephone Number: _____ Cell Number: _____

Email Address: _____ Marital Status: _____ Religion: _____

Medical Insurance

Primary Insurance: _____ Secondary Insurance: _____
Primary Insurance #: _____ Secondary Insurance #: _____
Please include a copy of cards.
Name of
Nearest Relative: _____ Relationship: _____

Address: _____
Street Address Apt # City State Zip Code

Telephone Number: _____ Cell Number: _____

Email Address: _____
Emergency or Alternate Contact (Can be friend or other family member)

Name: _____ Telephone # _____ Relationship: _____

Address: _____
Street Address Apt # City State Zip Code
Primary reason for your visit today and what can the Doctor help you with?
_____

How did you hear about Jersey Shore Geriatrics? _____
Most recent hospital _____

Do you have a Living Will ☐ Advanced Directive ☐ Durable Power of Attorney ☐ ?

What Physicians have you seen in the past 2 years? Primary: _____ Phone # _____

Other: _____ Phone # _____
Whom may we speak to on your behalf:

Name: _____ Telephone # _____ Relationship: _____

Name: _____ Telephone # _____ Relationship: _____

CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

I, _____, born, _____,
(Patient Name) (Date of Birth)

Authorize and request _____
(Specify Institution, Unit or Program)

to furnish to: Jersey Shore Geriatrics
15 School Road East, Suite #2
Marlboro, NJ 07746
Phone: 732-866-9922
Fax: 732-866-9970
Email: jsglabs@gmail.com

the following information: _____
(Specify All or What Portions of Record)

The above information is released for the following purpose and that purpose only. Any other use is forbidden.

Data Requested:

- ☐ Complete Record
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Pathology Reports
- ☐ Consultations
- ☐ EKG Reports
- ☐ Operative Records
- ☐ X-Ray Reports and films
- ☐ Laboratory Reports

Other: _____

Need and Purpose of Disclosure:

_____

THE FOLLOWING MUST BE COMPLETED PRIOR TO SIGNING THE AUTHORIZATION

I recognize that the information disclosed may contain drug/alcohol information that is protected by federal and state law. I do ☐ do not ☐ specifically consent to disclosure of such information.

I recognize that the information disclosed may contain mental health information that is protected by federal and state law. I do ☐ do not ☐ specifically consent to disclosure of such information.

I recognize that the information disclosed may contain information regarding sexually transmitted diseases or HIV / AIDS testing information. I do ◯ do not ◯ specifically consent to disclosure of such information.

I do ◯ do not ◯ onsent to transmission of my records via facsimile (FAX) machine.

I hereby release and forever discharge Jersey Shore Geriatrics; it's employees, and agents from any liability arising out of the release of my medical records as specified above and pursuant to this signed authorization.

This consent is subject to revocation at any time, except to the extent that the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate on:

_____
(Specify Date, Event, or Condition)

If left blank, this consent expires in ninety (90) days.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Witness) (Date)

JERSEY SHORE GERIATRICS

AUTHORIZATION FOR TREATMENT

The undersigned hereby consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary, which may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV infection.

RELEASE OF INFORMATION TO INSURANCE CARRIERS

Jersey Shore Geriatrics is authorized to furnish information, necessary to process claims, to an insurer, compensation carrier, or welfare agency who may be providing financial assistance for hospital care.

MEDICARE PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I request payment of the authorized Medicare benefits be made to Jersey Shore Geriatrics on my behalf for any services furnished me by or in the office , including physician services. I authorize any holder of medical and any other information about me to release to Medicare and its agents or intermediaries any information needed to determine these benefits or benefits for related services.

I further authorize the Medicare program to furnish medical or other information acquired on this visit acquired by its intermediary under the Title XVIII Program to the extent necessary to process any complementary coverage claim.

I hereby certify that I have read and fully understand the above authorizations.

Date _____ Signed X_____
PATIENT

_____ OR _____
WITNESS NEAREST RELATIVE

FINANCIAL RESPONSIBILITY

In consideration of the rendering of service to the patient, the undersigned guarantees the payment of any amount due for such services rendered by Jersey Shore Geriatrics over and above the amount covered by Medicare and/or insurance.

Date _____ Signed X_____

Witness _____ Procedure _____

You are entitled to keep your health information private. The HIPAA Privacy Authorization Form should be completed if you would like some person other than yourself to have access to your medical records information. This form gives your health care provider written authorization to release your health information to the persons you have named.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information pursuant to the Health Insurance Portability and Accountability Act ---- 45 C.F.R. Parts 160 and 164

Patient Name:	Date of Birth:	Today's Date:
Patient Address:		

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to Jersey Shore Geriatrics.
2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date) _____ **OR**
   b. ☐ all past, present and future periods. (check this box to include all of your medical records.)
3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). **OR**
   b. ☐ my complete health record with the exception of the following information (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV&AIDS)
      ☐ Alcohol/drug abuse treatment
      Other (please specify): _____
4. In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this Authorization, I authorize Jersey Shore Geriatrics to disclose information regarding my billing, condition, treatment and prognosis to third parties to the extent Jersey Shore Geriatrics needs to do so in order to determine my eligibility for statutory benefits, in connection with any legal proceedings or prospective legal proceedings, in order to establish, exercise or defend its legal rights, for the purpose of fraud detection and prevention or as required and permitted to do so by law.
5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
6. This authorization shall be in force and effect until _____, (date or event) at which time this authorization expires.
7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining statutory benefits from Jersey Shore Geriatrics.
8. I understand that my treatment, payment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative Date:

_____

Printed name of patient or personal representative and his/her relationship to patient

ADL & IADL SCORES

ADL – Activities of Daily Living	Independent 1 point	Needs Assistance 2 points	Dependent 3 points
1. Bathing	☐	☐	☐
2. Dressing	☐	☐	☐
3. Toileting	☐	☐	☐
4. Transfer	☐	☐	☐
5. Continence	☐	☐	☐
6. Feeding	☐	☐	☐

IADL – Instrumental Activities of Daily Living	Independent 1 point	Needs Assistance 2 points	Dependent 3 points
1. Ability to telephone	☐	☐	☐
2. Shopping	☐	☐	☐
3. Food preparation	☐	☐	☐
4. Housekeeping	☐	☐	☐
5. Laundry	☐	☐	☐
6. Mode of transportation	☐	☐	☐
7. Driving	☐	☐	☐
8. Responsibility for own medication	☐	☐	☐
9. Ability to handle finances	☐	☐	☐

Scores: ADL: _____/18 IDAL: _____/27

Patient Name: _____ Date: _____

JERSEY SHORE GERIATRICS

Patient Name: _____ Today's Date: _____

Medical History

Have you (the patient) been affected by any of the following medical conditions; If so, when was it first found? Answer to the best of your knowledge. Please specify Yes or No.

Yes	No	When?	Condition
			High Blood Pressure
			Heart Disease, Angina
			Thyroid trouble
			High cholesterol
			Stroke
			Neuropathy
			Poor circulation
			Diabetes
			Hepatitis
			Serious Head Injury
			Parkinson's Disease
			Drinking Problem
			Depression
			Syphilis or other venereal disease
			Seizures
			Street drug use
			Cancer
			Brain hemorrhage or hematoma
			Meningitis or encephalitis, which?
			Severe vision or hearing loss, which?
			Vitamin deficiency

Review of Symptoms

Have you (the patient) been having any of these problems? Specify Yes or No. Please describe

Yes	No	Problem	Description
		Change in personality	
		Change in speech	
		Any weakness	
		Change in Judgment	
		Confusion	
		Change in alertness	
		Delusions or hallucinations	
		Emotional difficulties	
		Sensation problems	
		Dryness of the mouth	
		Any recent falls or injuries	
		Difficulty with balance	
		Snoring	
		Shortness of breath	
		Coughing	
		Change in bowel habits	
		Blood in the stools	
		Increased or decreased sex interest	
		Trouble with urination or incontinence	
		Pain in joints or bones	
		Limited movement of arms or legs	
		Bleeding or enlarged spots on the skin	
		Unusual skin dryness or sweating	
		Unusual thirst	
		Extreme fatigue	
		Changes in sleep habits	
		Weight loss or gain	
		Inability to prepare or eat food	

Social History

How many children do you have? First and last names and where do they live? Please include step-children?

_____

_____

_____

_____

_____

Closest relative that is active in your daily life and able to assist in making medical decisions.

_____

How many years have you been married? Divorced? Names of all spouses and years married?

_____

_____

_____

_____

What hobbies are you involved in?

_____

_____

Please list all medical doctors that you have seen in the last five years and include reason and phone number.

_____

_____

_____

_____

*How is your sleep schedule?*_____

*What is the biggest meal you eat during the day?*_____

Social History

Where were you born? _____

Where have you lived? _____

_____

_____

_____

_____

Current Medical History

Please List the medical conditions currently affecting the person or that they are currently receiving treatments.

When did it begin?	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgical History

Please list all operations that you have had, with appropriate dates, and where was it performed.

Please be as specific as possible.

Date:	Operation	Place
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Psychiatric History

Please List all mental health of Psychiatric conditions or treatments the person has had, with the appropriate date of onset of each.

Date	Condition or Treatment
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Please indicate which family members have had any of the following medical conditions. Give the relationship to the patient (ex: Mother, Father, Sister, Brother). If known, please document the age of the family member when the diagnosis was made.

Condition	Family Member(s)	Age at Diagnosis
Dementia	_____	_____
Parkinson's Disease	_____	_____
Depression	_____	_____
Stroke	_____	_____
Heart Disease	_____	_____
Down Syndrome	_____	_____
Diabetes	_____	_____
Autism	_____	_____
Obsessive-Compulsive Disorder	_____	_____
Attention Deficit / Hyperactivity Disorder	_____	_____
Cancer (What kind?)	_____	_____

Family Report: Patient Behavior and Memory Problems

The information provided in this questionnaire helps the doctor decide if an important memory problem is present. It is best if this is filled out by someone with close, frequent contact with the patient. Many people have had minor and subtle problems with higher mental functions for years before they come to a doctor with questions about changes in memory. Please take a moment and go back in your mind a few months at a time and think about possible signs of memory problems. You may not be having any of these problems, and in that case please just record that information. We thank you for taking the time to complete this information.

The name of the person assisting you in completing this form: _____

Their telephone number: _____

1. Do you (the patient) sometimes have trouble writing checks, paying bills, or balancing a checkbook?

   Unable ☐ Need help ☐ Have trouble, but able ☐ Normal ☐

2. Do you (the patient) sometimes have trouble assembling tax records, business affairs, or papers?

   Unable ☐ Need help ☐ Have trouble, but able ☐ Normal ☐

3. Do you (the patient) sometimes have trouble shopping alone for clothes, household necessities, or groceries?

   Unable ☐ Need help ☐ Have trouble, but able ☐ Normal ☐

4. Do you (the patient) sometimes have trouble playing a game of skill or working on a hobby?

   Unable ☐ Need help ☐ Have trouble, but able ☐ Normal ☐

5. Do you (the patient) sometimes have trouble heating water, making a cup of coffee, or turning off the stove?

   Unable ☐ Need help ☐ Have trouble, but able ☐ Normal ☐

6. Do you (the patient) sometimes have trouble preparing a complete meal?

   Unable ☐ Need help ☐ Have trouble, but able ☐ Normal ☐

7. Do you (the patient) sometimes have trouble keeping track of current events?

Unable ☐ Need help ☐ Have trouble, but able ☐ Normal ☐

8. Do you (the patient) sometimes have trouble paying attention to, understanding, or discussing a TV show or book?

Unable ☐ Need help ☐ Have trouble, but able ☐ Normal ☐

9. Do you (the patient) sometimes have trouble remembering appointments, family occasions, holidays, medications?

Unable ☐ Need help ☐ Have trouble, but able ☐ Normal ☐

10. Do you (the patient) sometimes have trouble traveling out of the neighborhood, driving, or arranging to take buses?

Unable ☐ Need help ☐ Have trouble, but able ☐ Normal ☐

11. What was the ***very first*** sign that something had changed in the person's memory and thinking? When was the change noticed?

12. Please describe all other signs of problems with memory and thinking, along with the approximate time that they developed. Include here the ***story of the memory problem from start to now.***

Education and Employment

What is the highest level of formal education that you (the patient) completed?

_____

What was the primary type of work that you (the patient) performed?

_____

What other jobs have you (the patient) had?

_____

Have you (the patient) ever worked with chemicals, solvents, or heavy metals (for example, lead)?
No_____ Yes_____ If Yes, which ones? _____

Do you (the patient) have a history of exposure to radiation or radiation therapy?
No _____ Yes _____

Have you (the patient) ever had electroconvulsive (ECT) or "shock" therapy?
No _____ Yes _____

Have you (the patient) had any head trauma? I yes, please describe.
No _____ Yes _____ Describe: _____

Prior Evaluation

Have you had a brain imaging study (CT, PET scan or MRI of the brain)?
NO _____ Yes _____ Location_____

Have you had blood tests for memory loss?
No _____ Yes _____ If yes, where and when _____

Have you had an evaluation for memory loss before?
No _____ Yes _____ If yes, where and when _____

Health Habits

Did you ever smoke, if so, how many packs per day and for how many years?

_____

Do you drink alcoholic beverages on most days?
No _____ Yes _____ If yes, how many drinks per day? _____

Yesavage Geriatric Depression Scale

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life?

2. Have you dropped many of your activities and interests?

3. Do you feel that your life is empty?

4. Do you often get bored?

5. Are you in good spirits most of the time?

6. Are you afraid that something bad is going to happen to you?

7. Do you feel happy most of the time?

8. Do you often feel helpless?

9. Do you prefer to stay at home, rather than going out and doing new things?

10. Do you feel you have more problems with memory than most?

11. Do you think it is wonderful to be alive now?

12. Do you feel pretty worthless the way you are now?

13. Do you feel full of energy?

14. Do you feel that your situation is hopeless?

15. Do you think that most people are better off than you are?

Name: _____ **Date:** _____

MEDICATION LIST
(including Vitamins)

Medication	Dosage	Frequency

NAME: **Date of Birth:** _____

Allergies:

Pharmacy: _____ **TEL:** _____ **Fax:** _____