Internal Medicine and Pediatrics of Bloomfield, PC
Steve Kallabat, MD
Azrael Paredes, MD
Jamie Chioini-Baines, DO

Annual Registration Form

PEDIATRIC **ADULT**

Last Name_____ First Name_____ MI____

Date of Birth____/____/____ Age_____ Gender: **Male Female**

Address_____City_____ State____ Zip_____

Cell Phone (_____)_____ Home Phone (_____)_____

Emergency Contact:_____ Relationship_____ Phone _____
Can we discuss your medical/financial information with anyone? **Yes** or **No**
If so, who?_____ Relationship_____ Phone _____

Local Pharmacy Name_____ Address _____Phone_____

Mail Order Pharmacy_____Address_____Phone_____

Primary Insurance:_____

Subscriber Name:_____ DOB_____

Patient relationship to subscriber: **Self Spouse Parent Child Other**_____

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements, including payments due at the time of service as well as any referrals or prior authorizations needed. It is the insurance company that makes the final determinations, once this decision is made, we will not resubmit any claims.

Co-payments: All co-payments must be paid at the time of service as required by your insurance company, we cannot waive these fees.

Deductibles: Patients who have a high deductible insurance policy will be required to pay for the office visit, in full, at the time of service. The patient will also be responsible for any additional fees incurred associated with the office visit.

Premium Fee: An afterhours fee of $30 will be charged to your account for visits after 5pm Monday thru Friday and on the weekends.

Statement Fee: Any payments missed at the time of service are subjected to a billing fee of $10. A $25 fee will be attached to each additional statement sent for unpaid balances. After the third consecutive statement, we will no longer be able to see you in our office, and you will be sent to collections.

Missed Appointments: Patients who do not cancel 24 hours prior to their appointment will be charged a no show fee. If this fee is not paid before the next visit, we reserve the right to refuse treatment. Two consecutive missed appointments are grounds to be discharged from the practice. No show fees are as follows: Office Visits- $25, Well Child Visit -$50, Adult Physical Exam-$100.

Patient Signature/Guardian Signature_____ Date_____

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Review of Body System (Patient to fill out)

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HEART (CARDIOVASCULAR SYSTEM)

	chest pain		cramping in legs while walking		
	palpitations		awakening in the night with sudden difficulty breathing		
	dizziness/lightheaded		loss of consciousness		
	leg swelling		difficulty breathing while laying down		

LUNGS (PULMONARY SYSTEM)

	cough		cough with blood		wheezing
	difficulty breathing		excess sputum production		
	chronic cough (longer than one month)		difficulty breathing with exertion		

BOWELS (GASTROINTESTINAL SYSTEM)

	abdominal pain		bright red or maroon stools		nausea
	abdominal mass		difficulty swallowing		heartburn
	change in bowel health		vomit with blood		vomiting
	constipation		dark black stools		diarrhea

NERVOUS (NEUROLOGICAL SYSTEM)

	decreased memory		headaches (other)		loss of coordination
	difficulty speaking		headaches (migraines)		visual changes
	difficulty walking		seizures		weakness
	numbness in limbs		vertigo (spinning)		tremor

MUSCULOSKELETAL (MUSCLE & BONE)SYSTEM

	joint redness		morning stiffness		muscle ache
	joint deformity		joint pain		muscle fatigue/weakness
	chronic/long term back pain		joint swelling		chronic/long term neck pain

URINARY TRACT SYSTEM

	urinating frequently		urinating blood		painful urination
	awakening frequently to urinate		urinary leakage		weak urine stream

EAR, NOSE, AND THROAT

	runny nose		red eyes		sore throats
	nose bleeds		itchy/watery eyes		bad breath
	nasal congestion		oral lesions		enlarged tonsils
	snoring		excessive sneezing		ear aches
	hearing loss/muffled		ringing in the ears		vertigo

SKIN (DERMATOLOGY)

	rash		dark moles		growing skin lesions
	new skin lesion		easy bruising		slow healing cuts
	keloid/scar formation		loss of pigment		loss of hair

GYNECOLOGIC/UROLOGIC

	menopausal		change in menstruation		excessive bleeding
	painful menstruation		cyclical mood changes		breast tenderness
	breast mass/lump		nipple discharge		vaginal dryness/irritation
	vaginal discharge		penile discharge		penile lesion
	1st day of last menstrual period___/___/___		testicular pain		testicular mass

PSYCHIATRY

	depression		anxiety state		manic episode
	personality disorder		obsessive/compulsive		hallucinations
	post-traumatic syndrome		alcohol/substance addiction		

ENDOCRINE/GLANDULAR SYSTEM

	weight gain		weight loss		increased thirst
	increased appetite		tremors/shaky		stretch marks
	fatigue		increased perspiration		excessive hair growth

Patient signature:_____ **Date:**_____

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HEALTH MAINTENANCE FORM

NAME:_____ DOB: _____

Please update any changes in last year or since last appointment:

New surgeries:_____

New medicines: _____

New drug allergies:_____

Do you take daily baby Aspirin 81 mg? YES NO

Are you a current smoker? YES NO

FEMALE:
Please provide the following date of service for last:

STD Screen:_____

PAP:_____ Performing Physician: _____

Mammogram:_____

Colonoscopy:_____ Performing Physician: _____

DEXA Osteoporosis Scan:_____

Cardiac Calcium Score:_____

MALE
Please provide the following date of service for last:

STD Screen:_____

PSA test/rectal exam:_____

Who Performed Your Colonoscopy:_____

DEXA Osteoporosis Scan:_____

Cardiac Calcium Score:_____

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Annual Adult Wellness Exam

The purpose of an adult wellness exam is to address therapeutic lifestyle changes to optimize overall health. Annual wellness exams may also be called a physical, yearly check-up, or preventive visit. This discussion includes:

- BMI (Body Mass index, height, and weight)
- Nutrition/ diet
- Nutrients/ Vitamins
- Importance of Exercise
- Blood Pressure
- Review of Female Screening Guidelines: (pap smear for cervical cancer, STD screening, self breast exams, mammograms screening for breast cancer, DEXA screening for osteoporosis)
- Review of Male screening Guidelines: (STD screening, testicular cancer screening, prostate cancer screening)
- Guidelines for Screening for colon cancer by colonoscopy
- Immunization review: Tdap, Hepatitis A and B, Shingles, Pneumonia, HPV,
- Fasting Labs: CBC, BMP, Lipid Panel, TSH
- Screening for cardiac disease: EKG
- Screening for pulmonary disease: PFT
- Other screenings:
    - One time Hepatitis C screening for adults born between 1945-1965
    - Smokers: Guidelines for Low Dose CT screening for Lung Cancer
    - High Risk Cardiac Disease: Cardiac CT for Calcium Scoring
- Medication List Update
- Patient Portal sign up reminder for lab result explanations

An Adult Wellness Exam does not include discussion of new problems or detailed review of chronic conditions. Insurance does not pay for this benefit at the time of your yearly physical. We ask that the discussion be focussed on the above wellness topics. We'd be happy to see you for a follow up appointment to discuss any new or existing problems you may have.

I agree with the above policy and if I have other health issues, I will make a separate appointment to discuss these issues.

Signature: _____ **Date:**_____