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.

In our efforts to give you the best possible geriatric care we ask that you fill out the enclosed forms. This will assist the doctor in evaluating and treating your medical conditions. We also ask that you have your have your Medicare and other insurance cards available. 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.

Sincerely,

The Staff at Jersey Shore Geriatrics

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

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: M W D S 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 (Please circle all that apply) 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: __________

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 ________________________

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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 **______________ Consultations**
______________ Discharge Summary **______________ Operative Records**
______________ History and Physical **______________ X-Ray Reports**
______________ Pathology Reports **______________ X-Ray Films**
______________ EKG Reports **______________ 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 **O** do not **O** 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 **O** do not **O** 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 **O** do not **O** specifically consent to disclosure of such information.

I do **O** do not **O** consent 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)**

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HIPAA Authorization Form
Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Jersey Shore Geriatrics to use and/or disclose certain protected health information (PHI) about me to ________________________________.

This authorization permits Jersey Shore Geriatrics to use and/or disclose the following individually identifiable health information about me: my medical and surgical history, my medications, laboratory values, and my radiographic imaging.

The information will be used or disclosed for the following purpose at the request of the individual.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will not expire.

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Jersey Shore Geriatrics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Signed by: ______________________________ ______________________________
Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ______________________________
Print Patient's Name Date

____
Print Name of Patient or Legal Guardian, if applicable

Patient/Guardian must be provided with a signed copy of this authorization form.

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** **IADL:_______/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. Check 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
			Severe vision or hearing loss
			Vitamin deficiency

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.

Date:	Operation

Review of Symptoms

Have you (the patient) been having any of these problems? Click 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 interes	
		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	

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	____________________	________

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? (circle your answer)

   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) ever been a boxer?
No __________ Yes __________

Prior Evaluation

Have you had a brain imaging study (CT brain or MRI)?
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?....................................... YES / **NO**

2. Have you dropped many of your activities and interests? ....**YES** / NO

3. Do you feel that your life is empty?..**YES** / NO

4. Do you often get bored? ....**YES** / NO

5. Are you in good spirits most of the time? ....YES / **NO**

6. Are you afraid that something bad is going to happen to you? ......**YES** / NO

7. Do you feel happy most of the time? ....YES / **NO**

8. Do you often feel helpless? ....**YES** / NO

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

things? ....**YES** / NO

10. Do you feel you have more problems with memory than most?....**YES** / NO

11. Do you think it is wonderful to be alive now?...............YES / **NO**

12. Do you feel pretty worthless the way you are now?...........**YES** / NO

13. Do you feel full of energy?.............................YES / **NO**

14. Do you feel that your situation is hopeless?................**YES** / NO

15. Do you think that most people are better off than you are?.....**YES** / NO

Answers indicating depression are highlighted. Each answer counts one point; Scores greater than 5 indicate possible clinical depression and warrant follow up.

Name: ________________________________ **Date:** ______________

MEDICATION LIST

Start Date	Medication	Route	Dosage	Frequency	Increase/Decrease Stop Date	Renewals		

NAME: ______________________________ **Date of Birth:** ______________

Allergies: ______________________________

Pharmacy: ____________________ **TEL:** ______________ **Fax:** ______________