RODOLFO MALDONADO MD LLC

86 New Brunswick Avenue
Hopelawn, NJ 08861-2242
Phone: 732-826-1609
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Today's Date:	PCP:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One): Single / Mar / Div / Sep / Wid

E-Mail:	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	Social Security No.:	Phone No.: ( )

Apt:	Floor:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone No.: ( )

Race (Please check one box): ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander	Ethnicity (please check one box): ❑ Hispanic or Latino ❑ Not Hispanic or Latino

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Person Responsible For Bill:	Birth Date: / /	Address (If Different):	Cell Phone No.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer Address:	Employer Phone No.: ( )

Please indicate primary insurance: ❑ Medicare ❑ AARP ❑ Horizon NJ Health ❑ UnitedHealthCare ❑ BlueCrossBlueShield ❑ Qualcare ❑ Cigna ❑ Aetna ❑ Wellcare ❑ Amerigroup ❑ Amerihealth ❑ Oxford ❑ Empire BCBS ❑ Other: _____

Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-Payment: $

Name of Secondary Insurance (If Applicable):	Subscriber's Name:	Group No.:	Policy No.:

Patient's Relationship To Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative:	Relationship To Patient:	Cell Phone No.: ( )	Work Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rodolfo Maldonado MD LLC to release any information required to process my claims.

_____ _____

Patient/Guardian Signature *Date*

RODOLFO MALDONADO MD LLC

Patient's Name:	DOB:	Today's Date:

ALLERGIES

If you have no known allergies, please check the box to the right: ❑ No known allergies to report.

1. Medication _____ Reaction _____
2. Medication _____ Reaction _____

Major Illnesses (Please Check All That Apply)

Hypertension:	❑ Current	❑ Past	❑ N/A	Notes: _____
Diabetes:	❑ Current	❑ Past	❑ N/A	Notes: _____
Cancer:	❑ Current	❑ Past	❑ N/A	Notes: _____
Other:	❑ Current	❑ Past	❑ N/A	Notes: _____

SURGERIES

If you have no known surgeries, please check the box to the right: ❑ No known surgeries to report.

_____

SOCIAL HISTORY

Drink Alcohol:	❑ Currently	❑ In the past	❑ Never	How much and how often? _____
Use Tobacco:	❑ Currently	❑ In the past	❑ Never	How much? _____
Subs. Abuse:	❑ Currently	❑ In the past	❑ Never	What substance? _____

FAMILY HISTORY

Mother:	❑ Hypertension	❑ Diabetes	❑ Cancer	❑ Other (please specify): _____
Father:	❑ Hypertension	❑ Diabetes	❑ Cancer	❑ Other (please specify): _____
Brother:	❑ Hypertension	❑ Diabetes	❑ Cancer	❑ Other (please specify): _____
Sister:	❑ Hypertension	❑ Diabetes	❑ Cancer	❑ Other (please specify): _____
Grandmother (Paternal):	❑ Hypertension	❑ Diabetes	❑ Cancer	❑ Other (please specify): _____
Grandfather (Paternal):	❑ Hypertension	❑ Diabetes	❑ Cancer	❑ Other (please specify): _____
Grandmother (Maternal):	❑ Hypertension	❑ Diabetes	❑ Cancer	❑ Other (please specify): _____
Grandfather (Maternal):	❑ Hypertension	❑ Diabetes	❑ Cancer	❑ Other (please specify): _____

MEDICATIONS

If you are not currently taking any medications, please check the box to the right: ❑ No medications to report.

1. Medication _____ Dosage _____
2. Medication _____ Dosage _____
3. Medication _____ Dosage _____
4. Medication _____ Dosage _____
5. Medication _____ Dosage _____

To the best of my knowledge, the information provided above is accurate and complete.

_____ _____

Patient/Guardian Signature *Date*

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
    1. File a complaint with your provider or health insurer, or
    2. File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at **www.hhs.gov/ocr/hipaa/** or by calling **1-866-627-7748.**

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared,
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your healthcare,
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
- To protect the public's health, such as reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.

Signature: _____ **Date**: _____