NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient File #:_____ **Today's Date:**_____/_____/_____

WELCOME: *The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.*

INSTRUCTIONS: *Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.*

PERSONAL INFORMATION:

*Name: (First)*_____*(Middle)*_____*(Last)*_____*Jr., II, III, IV*
*Address:*_____*City:*_____*State:*_____*Zip:*_____
*Birth Date:*_____/_____/_____*Age:*___*Marital Status (Circle): Divorced Married Single Separated Widowed*
*Gender (Circle): Male / Female Home Phone: (*_____)_____-_____*Cell Phone: (*_____)_____-_____
*Social Security #:*_____*Email Address:*_____*@*_____
*Spouses Name:*_____*Names & Ages of Children:* _____
Is your spouse a patient in our office? ☐ **Yes** ☐ **No** *Primary Care Physician:* _____

Employer /Employment Status ☐*Employed* ☐*Unemployed* ☐*Full Time /* ☐*Part Time Student* ☐*Other*
*Business Name:*_____ *Occupation/Job Title:* _____
*Business Address:*_____
*Business Phone: (*_____)_____*Type of Work:*_____
Is it ok to contact you at work? ☐ *Yes* ☐ *No*

Emergency Contact Information
*Name: (First)*_____*(Middle)*_____*(Last)*_____*Jr., II, III, IV*
*Address:*_____*City:*_____*State:*_____*Zip:*
*Relationship:*_____*Home Phone: (*_____)_____-_____*Cell Phone: (*_____)_____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?
☐ *Yes* ☐ *No*
Who besides yourself is responsible for your bill? ☐*Self-Pay* ☐*Health Insurance*
☐*Medicare* ☐*Medicaid* ☐ *Worker's Comp*
☐*Auto Insurance* ☐ *Other (*Be Specific): _____
*Personal Health Insurance Carrier:*_____*Subscriber ID #:*_____
*Insured Person's Name:*_____*Group #:* _____
*Insured Person's Date of Birth:*_____/_____/_____
*Insured Person's Social Security #*_____
Auto or Workers' Comp Insurance Carrier & Claim #: _____

PRIMARY COMPLAINT: _____
When did it start? _____
*Describe the condition:*_____
*What do you think caused the problem?*_____
Rate the pain from 1-10: At it's worst ____ *At the present time* ____ *At least severe* ____
Does the pain travel? ☐ *Yes* ☐ *No* *If yes, from where to where?* _____
Is condition getting worse? ☐ *Yes* ☐ *No*
List the activities that this condition prevents you from doing? _____

*List past treatment for this condition and if they helped:*_____

_____

SECOND COMPLAINT:

When did it start? _____
Describe the condition: _____
What do you think caused the problem?
Rate the pain from 1-10: At it's worst ____ *At the present time* ____ *At least severe* ____
Does the pain travel? □ *Yes* □ *No* *If yes, from where to where?*
Is condition getting worse? | *Yes* *No*
List the activities that this condition prevents you from doing? _____

List past treatment for this condition and if they helped

THIRD COMPLAINT:

When did it start? _____
Describe the condition: _____
What do you think caused the problem?
Rate the pain from 1-10: At it's worst ____ *At the present time* ____ *At least severe* ____
Does the pain travel? □ *Yes* □ *No* *If yes, from where to where?*
Is condition getting worse? □ *Yes* □ *No*
List the activities that this condition prevents you from doing? _____

List past treatment for this condition and if they helped

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

Is there any other information that you feel would be relevant to your current condition(s) that was not covered? Please explain in the following section any information that you feel would be helpful to the doctor.

_____
_____
_____
_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to_____for services rendered to me.

REIMBURSEMENT POLICY:

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

_____
PATIENT PRINTED NAME

_____
PATIENT SIGNATURE

_____
DATE

Marron Wellness Center • 615 Hope Road, Building 2A • Eatontown, NJ 07724 • Tel: (732) 542-1272

REVIEW OF SYSTEMS

Patient Name: _____ *Patient File #:* _____ *Today's Date:*_____/_____/_____

INSTRUCTIONS: *Please fill out all of the sections. If none of the conditions apply, select "None."*

Constitutional:
- **None**
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Eyes/Vision:
- **None**
- Blindness
- ☐ Blurred Vision
- Cataracts
- Change in Vision
- ☐ Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching (around the eyes)
- ☐ Photophobia
- Tearing
- ☐ Wears Glasses or Contacts

Ears, Nose and Throat:
- **None**
- Bleeding
- ☐ Dental Implants
- Dentures
- ☐ Difficulty Swallowing
- Discharge
- Dizziness
- ☐ Ear Drainage
- ☐ Ear Infection(s)
- Ear Pain
- Fainting
- ☐ Headaches
- ☐ Head Injury (history of)
- ☐ Hearing Loss
- Hoarseness
- ☐ Loss of Smell
- ☐ Nasal Congestion
- Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Rhinorrhea (runny nose)
- ☐ Sinus Infections
- Snoring
- ☐ Sore Throats
- Tinnitus (ringing in the ears)
- ☐ TMJ Disorder

Cardiovascular:
- **None**
- Angina (chest pain or discomfort)
- ☐ Chest Pain
- Claudication (leg pain or achiness)
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Orthopnea (difficulty breathing while lying)
- ☐ Palpitations (irregular or forceful heart beat)
- ☐ Paroxysmal Nocturnal Dyspnea (shortness of breath at night)
- ☐ Shortness of Breath
- ☐ Swelling of Leg(s)
- Ulcers
- ☐ Varicose Veins

Gastrointestinal:
- **None**
- ☐ Abdominal Pain
- Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- Diarrhea
- ☐ Difficulty Swallowing
- Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- Jaundice (yellowing of the skin)
- Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber (quality)
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- Vomiting
- ☐ Vomiting Blood

Respiration:
- **None**
- Asthma
- ☐ Coughing up blood
- ☐ Shortness of Breath
- ☐ Sputum Production
- Wheezing

Endocrine:
- **None**
- ☐ Cold Intolerance
- Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Frequent Urination
- Goiter
- Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Skin:
- **None**
- ☐ Changes in Nail Texture
- ☐ Changes in Skin Color
- ☐ Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness, prickling, or tingling)
- Rash
- ☐ History of Skin Disorders
- ☐ Skin Lesions or Ulcers
- ☐ Varicosities

Nervous System:
- **None**
- Dizziness
- ☐ Facial Weakness
- ☐ Headaches
- ☐ Limb Weakness
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- ☐ Slurred Speech
- Stress
- Strokes
- Tremors
- ☐ Unsteadiness of Gait

Allergy:
- **None**
- ☐ Anaphylaxis (history of)
- ☐ Food Intolerance
- Itching
- ☐ Nasal Congestion
- Sneezing

Hematology:
- **None**
- Anemia
- Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusion(s)
- ☐ Bruises easily
- Fatigue
- ☐ Lymph Node Swelling

Psychological:
- **None**
- ☐ Anhedonia (inability to experience joy or enjoy life)
- Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Change(s)
- ☐ Bipolar Disorder
- Confusion
- ☐ Convulsions
- ☐ Depression
- Insomnia
- ☐ Memory Loss
- ☐ Mood Change(s)

Female:
- **None**
- ☐ Birth Control Therapy
- ☐ Breast Lumps / Pain
- ☐ Burning Urination
- Cramps
- ☐ Frequent Urination
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Male:
- **None**
- ☐ Burning Urination
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy or Dribbling
- ☐ Prostate Problems
- ☐ Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient:

_____ _____

Doctor Signature *Date*

Marron Wellness Center

615 Hope Road, Building 2A
Eatontown, New Jersey 07724
Tel: 732-542-1272 * Fax: 732-542-2315

Consent to Use or Disclose Health Information
(HIPAA Disclosure)

I authorize **Marron Wellness Center** to use and disclose the health and medical information of (PATIENT'S NAME)_____for the purposes of Treatment, Payment and Health Care Operations.*

*__Treatment__ (includes activities performed by a health care provider, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

*__Payment__ (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

*__Health Care Operations__ (includes the necessary administrative and business functions of our office).

You may review **Marron Wellness Center** "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. **Please verify that you have received a copy of our Notice of Privacy Practices by placing your initials here_____.**

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the notice may change also. A summary of the notice will be posted in our office indicating the effective date of the notice in the upper right hand corner. We will offer you a copy of the notice on your first visit to us after the effective date of the then current notice. We will also provide you with a copy of the notice upon your request.

As more fully explained in the notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that MARRON WELLNESS CENTER has already used or disclosed the information in reliance on this Consent.

_____ _____
PATIENT'S SIGNATURE/SIGNATURE OF AUTHORIZED INDIVIDUAL **DATE**

_____
AUTHORIZED INDIVIDUAL'S RELATION TO PATIENT

Marron Wellness Center
615 Hope Road, Building 2A
Eatontown, New Jersey 07724
Tel: 732-542-1272 * Fax: 732-542-2315

Patient Information Release

Patient Name:_____D.O.B:_____
I hereby give my permission to release medical information regarding myself to family, friends, physicians, or others listed below: (This would include appointment schedules, X-rays, receipts, health records, and any other information that pertains to your treatment)

_____

_____

_____

The following information will assist us in your care and in any communication with you while protecting your confidentiality.

Please circle "YES" or "NO" and fill in the necessary information. List only the phone # where you want to be notified.

I give my permission to:

YES NO Leave a MESSAGE to remind me of my appointments
Home #_____Work #_____Other # _____

YES NO Leave a MESSAGE requesting that you call our office back
Home #_____Work #_____Other # _____

YES NO Fax any information regarding my condition to my family doctor or a physician to whom I may be referred to

_____ _____
Patient's Signature/Signature of Authorized Individual Date

Marron Wellness Center Office Policies

Welcome to Marron Wellness Center. We are pleased you have chosen our facility for your health and wellness needs. For your convenience we have listed our policies and procedures. If you have any questions regarding these policies, please let our staff know and we will be glad to clarify any questions you may have.

Cancellation/No Show

If you are unable to keep your scheduled appointment, we ask that you let us know as soon as possible. We require at least **24-hour notice**, so that your appointment time can be reallocated to someone else. Please notify the office at 732.542.1272 so we can reschedule your appointment more efficiently. If the office is closed, please leave a message on our answering machine and a staff member will return your phone call during office hours.

We understand that there are times when extenuating circumstances prohibit you from keeping a scheduled appointment. After three (3) missed or cancelled appointments (less than 24 hr) a fee of **$25.00** will be billed to you for any future missed and/or cancelled appointments (less than 24 hr). This amount cannot be billed to your insurance company.

Late Arrivals

Late arrivals create delays for both providers and other patients. If you see that you are running late, please notify the office as soon as possible. The provider may not be able to see you which may result in the rescheduling of your appointment for an alternate time. If you are late for an appointment, you will be seen as soon as possible, though your office visit may need to be shortened in length.

Sometimes for reasons beyond our control the office may run behind schedule. Emergencies may impact our schedules and result in unpredictable waiting periods. We make every effort to maintain our schedule and minimize any inconvenience to you. However emergencies do occur. If a delay occurs we will inform you upon arrival and gladly reschedule your appointment if it conflicts with your schedule.

Payments

Payment is due at the time of service. For your convenience we accept cash, check, debit and credit cards for payment.

Returned Check Policy: There is a **$35.00** fee for all returned checks. If we receive a returned check, you will be responsible for the balance, including the fee, by either cash or credit card.

Cell Phones

As a courtesy to our practitioners and other patients, please turn all phones to either vibrate or silent mode when coming into the office. If you need to take an important phone call just excuse yourself from the office and take the phone call in the hallway. We do not allow any phone calls to be taken in any of the treatment areas.

Please arrive 5-10 minutes before your scheduled appointment and notify the front desk of any insurance, phone number, or address changes.

I have read and understand the Office Policies of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

Patient Name:_____ Date: _____

Patient Doctors / Previous Care

(Please identify all doctors your currently see or have seen within the last year)

	Doctor Name	Town	Date of Last Visit
Medical/Primary			
OBGYN			
Orthopedist			
Pain Management			
Neurologist			
Cardiologist			
Podiatrist			
Chiropractic			
Physical Therapy			
Acupuncture			