Annandale Family Practice, LLC

56 Payne Road, Suite 21, Lebanon, NJ 08833
Phone: (908)238-0100 Fax: (908)238-0951

PRE-VISIT GUIDELINE

- Arrive 15 minutes early so paperwork can be put into the system and you can be roomed in a timely fashion.
- Notify your insurance that Dr. Sacchieri or Dr. Collins is your new primary care provider(PCP). Please bring your insurance card to each visit as it must be scanned every time.
- Copay is due at time of both nurse and doctor visits. Checks should be made out to Annandale Family Practice. We accept Discover, Visa, Mastercard, and Diners Club International cards.
- Bring immunization records and or general records from prior doctor.
- A No Show fee of $25 is due for all appointments cancelled less than 24 hours in advance.
- Minimum Processing times:
    - Prescription & Refill requests: **72 hrs**
    - Insurance referrals: **48-72 hours**
    - All forms dropped off at office: **5 days min.**

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Patient Registration Form

Name (last, first): _____

Date of Birth: _____SS#_____ Sex_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Alternate #:_____

Email Address: _____

Race: _____ Ethnicity: _____

Preferred Language: _____

Responsibility Party Information (if different from above):

Name (last, first): _____Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____Relationship:_____

Primary Insurance: _____

Subscriber Name: _____Date of Birth: _____

ID #: _____

Group #: _____Relationship:_____

Secondary Insurance: _____

Subscriber Name: _____Date of Birth: _____

ID #: _____

Group #: _____Relationship:_____

Emergency Contact Information:

Name: _____

Contact #_____Relationship:_____

Signature_____ Date _____

Annandale Family Practice – Medical History Form

In order to ensure that we are aware of your complete medical history and to better assess your individual risk factors, please take a few minutes to answer these questions.

Name: _____ Date: _____
Date of Birth: _____ Spouse/Significant Other: _____

Other Household Members: (Name, age, and relation)
_____
_____
_____
_____

Medical/Psychiatric History: (Age at onset)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Previous Surgeries or Hospitalizations: (please state year)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Health Maintenance: (most recent)
Flu vaccine: _____ Pneumococcal Vaccine: _____ Tetanus: _____
Stress Test: _____ PSA (prostate): _____ Colonoscopy: _____
Pap test: _____ Mammogram: _____ Last menstrual period: _____

Medications: (include over the counters, herbals, supplements, and vitamins)

Name of Medication	Dose	Directions

Preferred Pharmacy: _____ **Phone** #:_____

Allergies: (medication, food, and environmental)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Annandale Family Practice – Medical History Form

Name: _____ Date: _____

Social History:
Are you: Married _____ Domestic Partner _____ Single _____ Divorced _____ Widowed _____
Occupation: _____ Employer: _____
Do you smoke? Y/N Type: _____ Packs/day: _____ Years smoked: _____
Do you drink alcohol? Y/N Type: _____ Amount: _____ Frequency: _____
Do you use illicit drugs? Y/N Have you used illicit drugs in the past? Y/N
Type: _____ Route: _____ Amount: _____ Frequency: _____ Last Use: _____
Do you have concerns for eating disorders? Y/N Domestic Violence? Y/N

Family History: (relation, age at diagnosis; if deceased, age at time of death)
Heart Disease: _____ High Blood Pressure: _____
Heart Failure: _____ High Cholesterol: _____
Stroke: _____ Aneurysm: _____
Poor Circulation: _____ Amputation: _____
Emphysema: _____ Asthma: _____
COPD: _____ Chronic Bronchitis: _____
Cancer (type): _____ Oxygen used at home: _____
Diabetes: _____ Thyroid Disease: _____
Liver Disease: _____ Hepatitis: _____
Kidney Disease: _____ Kidney Failure: _____
Dementia: _____ Arthritis: _____
Other: _____
_____

Review of Symptoms: (circle all the symptoms that you have been experiencing)
Cardiac: chest pain, palpitations, pressure in the chest, heaviness in the chest, heart murmur
Lungs: shortness of breath, chronic cough, coughing up blood, wheezing
GI: nausea, vomiting, diarrhea, chronic constipation, hemorrhoids, blood in the bowels, black tarry stools, abdominal pain, pelvic pain, heart burn, indigestion, acid reflux
GU: difficulty urinating, blood in urine, pain with urination, urinary incontinence, frequent urination, waking at night to urinate, circumcision, bedwetting, daytime wetting
Reproductive: vaginal discharge, vaginal itching, heavy/painful/irregular periods, penile discharge, Age of first period _____ Last menstrual period _____
MS: Swelling in legs, chronic joint pain (If yes, which joint _____), back pain (chronic, recurrent), muscle aches, muscle deformity
Derm: lumps, bumps, moles of concern, rash, sores/lesions, tattoo, piercing
Neuro: numbness, tingling, tremor, seizure, convulsions, headaches (migraine, tension, cluster, sinus)
Eyes: vision loss, blurred vision, double vision, blindness
Wears: Glasses ____ Contacts _____ To drive/To read/All the time
Ears: hearing loss, vertigo, ringing in the ears, hearing aid (right/left/both), failed hearing screening
Nose: bloody nose, obstruction, deviated septum, snoring, post nasal drip
Throat: sore throat, lump in throat, change in voice, difficulty swallowing
Psych: depressed, moody, anxiety, panic attacks, hallucinations, tearfulness, lack of motivation
Gen: fever, chills, weight loss, weight gain, fatigue, lack of energy, change in appetite, change in sleep
Other: _____

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Authorization for Disclosure of Protected Health Information

I, _____hereby authorize _____to disclose information from the records of _____(__/___/__)
Patient Name Date of Birth

The information is to be:

Released from: **Annandale Family Practice** To: _____ _____ _____	OR	Released to : **Annandale Family Practice** From: _____ _____ _____

Purpose for request:____ For personal use only ___Transferring care to another local practice
____ Relocation out of area
____ Insurance change related ___ Other:_____

The following information is to be released: (please check one)

_____**Entire Medical Record**. Records specifically protected under State and Federal Confidentiality Statutes. I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of substance abuse , AIDS/HIV related, genetic, venereal disease, or tuberculosis information, which are protected under State and Federal law prohibits and further disclosure without written consent of the persons to whom it pertains or otherwise protected by law.

____**Only specific portions of the medical record**. Itemize portions of record and time period of records to be released and indicate specific records that may not be released_____
_____

Having read the above information , I release Annandale Family Practice, LLC, its employees, staff, and agents from all legal responsibility or liability that may arise from the disclosure of information set forth above relating to my protected information. I understand that this authorization will remain in effect for 180 days or until I provide a written notice of revocation to Annandale Family Practice, LLC at the address listed above. The revocation will be effective immediately upon Annandale Family Practice's receipt of the written notice. I understand that revocation may not be made if the action has already been acted upon based on prior authorization.

_____ _____
Date Patient's Signature

_____ _____
Date Witness's Signature

Annandale Family Practice, LLC
Patient Communication Form

Patient Name (Print): _____ DOB: _____
Date: _____

A. Family and Friends. It is the office policy of **Annandale Family Practice, LLC** not to release confidential medical information regarding your treatment to family members or friends, (i) except for parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on or make changes to the form, please confirm this in writing).

Name	Relationship to self/patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

□ CONSENT DECLINED

B. If we are not able to speak with you directly by phone, is it ok to leave a detailed message that may or may not contain personal medical information?

Okay to leave detailed voicemail?

□ Yes (Please specify phone number) _____

_____

□ No thank you

By my signature, I acknowledge that I have received the Notice of Privacy Practices of Annandale Family Practice, LLC.

X_____

OFFICE USE ONLY

Signature of staff updating in chart

_____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By your signature below, you indicate that you have accessed and read the document entitled "Annandale Family Practice, LLC Notice of Privacy Practices."

_____	_____
Patient Name	**Date of Birth**
_____	_____
Patient Signature (over 18 yrs old)	**Date**
_____	_____
Parent or Guardian Signature (under 18 yrs old)	**Date**

_____

Relationship to Patient