Atlantic Rheumatology and Osteoporosis Associates, P.A.

DEBORAH PASIK, M.D., F.A.C.R.
VANDANA SINGH, D.O., F.A.C.R.
JODI SEBASTIAN, M.D., F.A.C.R.

8 SADDLE ROAD
SUITE 202
CEDAR KNOLLS, NJ 07927

TELEPHONE: (973) 984-9796
FAX: (973) 984-5445

Dear Patient:

In an effort to make your medical records as complete as possible, please bring the following items with you to your first appointment:

1. Completed New Patient Forms
2. Primary Care Physician Information (Full name, address, phone & fax number)
3. All medications and dosages you are taking on a regular basis
4. Current Pharmacy Information (Full name, address, phone & fax number)
5. The following recent records
    a. Blood work
    b. X-rays (films & reports)
    c. MRIs Cat scan & Bone Density reports (films not needed)
6. Current Insurance card
7. Picture ID
8. Prescription card if applicable

If you have any questions, please do not hesitate to contact us at 973-984-9796.

Thank You,

Atlantic Rheumatology and Osteoporosis Associates

Your Appointment is on_____ @_____ AM PM

1/6/2012

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NEW PATIENT QUESTIONNAIRE

Name:_____ Date:_____

Date of Birth:_____ Height:_____ Weight:_____

Primary Physician:_____

Referring Physician:_____

Current Medications

Please list all medications and dosages:_____

_____

_____

_____

_____

_____

_____

Medical History

Please list any current or past medical diagnoses:_____

_____

_____

_____

_____

_____

_____

Surgical History

Please list all operations and approximate dates:_____

_____

_____

_____

Allergies

Medication(s): Yes No
If Yes which Medication(s)?_____

Shellfish(Circle): Yes No Eggs(Circle): Yes No Medical Dye(Circle): Yes No

Family History

Do you have a family member with: (Circle and indicate which family member)

Rheumatoid Arthritis Lupus Scleroderma Psoriasis Chrohn's Disease

Gout Osteoporosis Multiple Sclerosis Sjogren's Syndrome

Social History

Smoking (Circle): Yes No Quit When?_____

Alcohol (Circle): Beer Wine Liquor Drinks per week?_____

Have you had a Bone Density Scan? Yes No

When?_____ Where?_____

Result?_____

Patient Information Form

Name:_____

Home Address:_____ City:_____ State:____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address: _____

Social Security#:_____ Date of Birth:_____

Current Pharmacy:_____ City:_____

Language (Circle): English Spanish Russian Hindi/Tamil Other

Race (Circle): American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander

African American Caucasian Hispanic Other Race Do not wish to disclose

Marital Status (Circle): Single Married Divorced Widowed Other Sex (Circle): Male Female

Employment Status (Circle): FT PT Retired Not Employed Student

Primary Care Physician:_____ City:_____ Phone:_____

Referring Physician:_____ City:_____ Phone:_____

Whom may we contact in case of an emergency? Relation to Patient:_____

Name:_____ Phone:_____

Address:_____

Is Medicare your Primary? Y N Why (Circle)? Age Disability

Did you sustain an injury at work? Y N

Are you covered under an employer or union policy? Y N

Are your injuries accident related? Y N

Are your injuries due to an auto accident Y N

I have read and completed the requested information on this sheet. I certify that this information is true and correct to the best of my knowledge and will notify you of any changes in my status or the above information.

_____ _____

Signature Date

1/6/2012

Insurance Information

Primary Insurance Company:	
Insurance Company's Address:	
Subscriber's Name:	ID#:
Subscriber's DOB:	Subscriber's SSN:
Patient's Relationship to Subscriber:	

Secondary Insurance Company:	
Insurance Company's Address:	
Subscriber's Name:	ID#:
Subscriber's DOB:	Subscriber's SSN:
Patient's Relationship to Subscriber:	

Tertiary Insurance Company:	
Insurance Company's Address:	
Subscriber's Name:	ID#:
Subscriber's DOB:	Subscriber's SSN:
Patient's Relationship to Subscriber:	

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

_____ _____

Signature Date

Patient Contact Authorization Form

Patient Name:_____

How may we contact you?

	Leave a message?	
Home Phone:	**Y** **N**	Detailed Non-Detailed
Work Phone:	**Y** **N**	Detailed Non-Detailed
Cell Phone:	**Y** **N**	Detailed Non-Detailed
Work Fax Number:		
Home Fax Number:		

To whom may we speak about your appointments, treatment, insurance or billing? (Please Check Off)

Name	Appointments	Treatments	Billing/Insurance

☐ Speak only to me about my appointments, treatment, insurance and billing.

How would you like to be notified of upcoming appointments? By Phone By Text

If by phone, what number would you like to receive the call? Home: _____

Cell:_____

What time of day would you like to receive your reminder? Morning Afternoon Evening

_____ _____

Patient Signature Date

1/6/2012

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Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our commitment here at Atlantic Rheumatology & Osteoporosis Associates, PA is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis, or other testing not limited to but including x-rays and MRI's.
- For payment purposes, we will need to share your information with your insurance(s).
- During health care operations, we may need a second opinion.

We here at Atlantic Rheumatology & Osteoporosis Associates, PA are committed to obeying all Federal State and Local Laws and Regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer Mary at 973-984-9796.

This agreement will remain active for as long as I am a current patient of the practice. I understand that it will be void after three years from my last office visit.

I have read and understand the above Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Print Name: _____

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At the time of service I, (print) _____, agree to pay *Atlantic Rheumatology & Osteoporosis Associate, PA* my co-payment and/or all charges for my visit.

I understand the following:

- Payment for any professional service(s) provided by *Atlantic Rheumatology & Osteoporosis Associate, PA* is the sole obligation of myself, my parent or my legal guardian.
- If I am using my insurance, *Atlantic Rheumatology & Osteoporosis Associate, PA* will bill my insurance company. However, if my insurance company does not pay for any reason, it is my obligation to contact them and correct any issues in a timely manner.
- I am responsible to make payment for any charges not covered by my insurance company, regardless if my insurance is in or out of network.
- If a collection agency is used, my account will be subject to all costs and charged related to said collection agency with a minimum of $40.00 and a maximum of 30% of the account.
- I f my check is returned for any reason from the bank, my account will be subject to a charge of $40.00, plus the amount of the check.

I understand that payment for any professional service(s) provided by *Atlantic Rheumatology & Osteoporosis Associate, PA* is the sole obligation of myself, my parent or my legal guardian regardless of my insurance coverage.

This agreement will remain active for as long as I am a current patient of the practice. I understand that it will be void after three years from my last office visit.

Circle One: Patient Guardian

_____
Print Patient or Legal Guardian

_____ _____
Signature of Patient or Legal Guardian Date

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To Our Patients:

We are continuously striving to provide excellent customer service. Unfortunately, we have found that the process of tracking down all relevant blood work and other tests has been overwhelming to our staff and compromising our overall office flow.

As such we are respectfully requesting that you take charge of obtaining your outside testing results for us. Please feel free to call to find out what is missing in your chart before your office visit so that you can call the facility and have them fax us the results.

We apologize for the inconvenience, but we are trying to maintain our fees without any unnecessary increases.

Please print and sign your name below. Thank you for your cooperation.

Patient Signature:_____ Date:_____

Print Name:_____

1/6/2012