

**Welcome to Our Office**

Patient Name \_\_\_\_\_ Sex: M F Birthdate \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_  
If Patient is a Minor. Give Parent's or Guardian's Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Todays Date \_\_\_/\_\_\_/\_\_\_  
Preferred Language:  English  Spanish Ethnicity:  Hispanic  White Race:  Latino  
 Sign  Other  Asian  Black  Non Latino  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work # \_\_\_\_\_  
Student  Yes  No School \_\_\_\_\_  
Employer \_\_\_\_\_ Length of Employment \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Spouse \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_  
Employer \_\_\_\_\_ Length Of Employment \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell Phone # \_\_\_\_\_ Work # \_\_\_\_\_  
**Emergency Contact** \_\_\_\_\_ **Phone #** \_\_\_\_\_  
(Relationship)

**Responsible Party if Other Then Patient**

Patient Name \_\_\_\_\_ Sex: M F Birthdate \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work # \_\_\_\_\_  
Employer \_\_\_\_\_ Length of Employment \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Referring Dr.** \_\_\_\_\_ Phone # \_\_\_\_\_  
(First) (Last) Fax # \_\_\_\_\_  
Street Address \_\_\_\_\_  
**Primary Dr.** \_\_\_\_\_ Phone # \_\_\_\_\_  
Fax # \_\_\_\_\_  
Street Address \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Phone # \_\_\_\_\_  
City \_\_\_\_\_ Fax # \_\_\_\_\_

Raritan Valley Surgical Associates

Patient History

Patient Name \_\_\_\_\_ Todays Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason(s) for seeing this physician: \_\_\_\_\_

Symptoms: \_\_\_\_\_

**Medical History: (Please check all disease incurred)**

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Stroke       |
| <input type="checkbox"/> Gastritis                   | <input type="checkbox"/> Thyroid Disease      | <input type="checkbox"/> HIV             | <input type="checkbox"/> COPD         |
| <input type="checkbox"/> Emphysema (COPD)            | <input type="checkbox"/> Peptic Ulcers        |  |                                       |
| <input type="checkbox"/> Hypertension                | <input type="checkbox"/> Hypercholesterolemia |  |                                       |
| <input type="checkbox"/> Coronary Artery Disease     | <input type="checkbox"/> Injuries _____       |  |                                       |
| <input type="checkbox"/> Peripheral Vascular Disease |   |  |                                       |

**Surgical History:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Colon Surgery          | <input type="checkbox"/> Appendectomy     | <input type="checkbox"/> Breast Surgery               |
| <input type="checkbox"/> Cancer Surgery         | <input type="checkbox"/> Hernia Repair    | <input type="checkbox"/> Hysterectomy                 |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Vascular Surgery | <input type="checkbox"/> Pacemaker (Bring Card)       |
| <input type="checkbox"/> Colonoscopy            | <input type="checkbox"/> Defibrillator    | <input type="checkbox"/> Hip Replacement (Bring Card) |

List Other Surgery: \_\_\_\_\_

\* Do you require prophylactic antibiotics prior to medical/surgical procedures?  Yes  No

**Family History: (F) Father, (M) Mother, (S) Siblings & (C) Children**

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hemophilia   | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Allergies    | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Other          | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer        |
|   |                                       | Type: _____                            |

**Please check any pertaining illness you may have:**

- |  |  |  |  |
|--|--|--|--|
| <b>Skin:</b>                             | <b>Eyes:</b>                               | <b>Respiratory:</b>                          | <b>Cardiovascular:</b>                       |
| <input type="checkbox"/> Eruptions       | <input type="checkbox"/> Eyestrain         | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Chest Pain          |
| <input type="checkbox"/> Cyanosis        | <input type="checkbox"/> Double Vision     | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Jaundice        | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Bloody Cough        | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Shingles        | <input type="checkbox"/> Inflammation      | <input type="checkbox"/> Productive Cough    | <input type="checkbox"/> Heart Disease       |
| <input type="checkbox"/> Ulcer           | <input type="checkbox"/> Tearing           | <input type="checkbox"/> Last Chest X-Ray    | <input type="checkbox"/> Leg Swelling        |
|  | <input type="checkbox"/> Blurring Vision   |  | <input type="checkbox"/> Rapid Heart Beat    |
|  |  |  | <input type="checkbox"/> Shortness of Breath |
| <b>Ears:</b>                             | <b>Head:</b>                               | <b>Nose:</b>                                 | <b>Throat:</b>                               |
| <input type="checkbox"/> Deafness        | <input type="checkbox"/> Headache          | <input type="checkbox"/> Colds               | <input type="checkbox"/> Soreness            |
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Bloody Nose         | <input type="checkbox"/> Redness             |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Obstruction         | <input type="checkbox"/> Hoarseness          |
| <input type="checkbox"/> Pain            |  | <input type="checkbox"/> Post Nasal Drip     |  |
| <input type="checkbox"/> Discharge       |  | <input type="checkbox"/> Sinusitis           |  |

Raritan Valley Surgical Associates  
Patient History (Page 2)

Patient Name \_\_\_\_\_ Todays Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Please check any pertaining illness you may have (Continued):

Psychological Status:

\_\_\_ Headaches  
\_\_\_ Paralysis  
\_\_\_ Stress  
\_\_\_ Memory Loss  
\_\_\_ Seizures

Neuromuscular:

\_\_\_ Weakness  
\_\_\_ Joint Pain  
\_\_\_ Varicosities  
\_\_\_ Deformities

Genitourinary:

\_\_\_ Sores  
\_\_\_ Frequency  
\_\_\_ Excessive Urination  
\_\_\_ Incontinence  
\_\_\_ Blood in Urination  
\_\_\_ Pain on Urination  
\_\_\_ Kidney Disease

Female Reproduction:

\_\_\_ Periods  
    Frequency of Periods \_\_\_\_\_  
    Types of Periods \_\_\_\_\_  
    Duration \_\_\_\_\_  
    Number of Pregnancies \_\_\_\_\_

Gastrointestinal:

\_\_\_ Appetite  
\_\_\_ Constipation  
\_\_\_ Nausea  
\_\_\_ Hernia  
\_\_\_ Flatulence  
\_\_\_ Stool Changes  
\_\_\_ Belching  
\_\_\_ Distress  
\_\_\_ Diarrhea  
\_\_\_ Vomiting

Social History:

Do you smoke currently?  Yes  No  
Are you an ex-smoker?  Yes  No  
Do you drink Alcohol?  Yes  No

Pack per day \_\_\_\_\_ Years \_\_\_\_\_  
Pack per day \_\_\_\_\_ Years \_\_\_\_\_  
Quantity per week \_\_\_\_\_

Allergies:

List Allergies to Medications: \_\_\_\_\_

Are your allergic to:

IV Dye/X Ray Contrast  Yes  No  
Iodine  Yes  No

Did you have a Mammogram done?  Yes  No

Where \_\_\_\_\_

When: \_\_\_\_\_



**ACKNOWLEDGEMENT OF NON-PARTICIPATING STATUS**

The physicians of Raritan Valley Surgical Associates will only accept out of network benefits with the following managed care companies.

**AMERIHEALTH  
AMERICHOICE  
BEECH STREET  
BENEFIT CONCEPTS  
CHN  
COVENTRY  
DEVON  
FIRST HEALTH  
GALAXY  
GHI  
GREAT WEST HEALTHCARE  
HEALTHNET  
HEALTHCARE PAYERS COALITION  
HORIZON NJ HEALTH (MEDICAID)  
INTRAGROUP  
LIBERTY MUTUAL INSURANCE CO  
LOCAL 825  
MULTIPLAN  
MAGNACARE  
MASTERCARE  
MEDICAID  
NATIONAL ASSOC LETTER CARRIERS  
PHCS  
PPO NEXT  
QUALCARE  
UHC (MEDICAID)  
THREE RIVERS  
TRI CARE  
UNIVERSITY HEALTH PLAN  
UP AND UP  
VIANT**

**As a Courtesy, our office will submit ALL claims to the appropriate institutions and work diligently to obtain Maximum reimbursement allowed by your individual policy. Please note you will be responsible for ALL DEDUCTIBLES and/or CO-INSURANCE that may apply to your outstanding claims.**

**Patient Name \_\_\_\_\_ Date \_\_\_\_\_**

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

INSURANCE COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP CODE \_\_\_\_\_

INSURANCE ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

PHONE # \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE # \_\_\_\_\_

INSURANCE REFERRAL      PRIMARY \_\_\_\_\_ YES \_\_\_\_\_ NO

CO-PAYMENT              SPECIALIST \$ \_\_\_\_\_ DEDUCTIBLE \$ \_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE COMPANY \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

INSURANCE ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

PHONE # \_\_\_\_\_

INSURANCE REFERRAL              SECONDARY \_\_\_\_\_ YES \_\_\_\_\_ NO

CO-PAYMENT              SPECIALIST \$ \_\_\_\_\_ DEDUCTIBLE \$ \_\_\_\_\_

**\*\*\*\*IS THIS A WORKERS COMPENSATION CASE?    YES \_\_\_\_\_ NO**

**IF YES, PLEASE NOTIFY THE RECEPTIONIST FOR A WORKERS  
COMPENSATION QUESTIONAIRE.**

**\*\*I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER  
INFORMATION NECESSARY TO PROCESS MY MEDICAL INSURANCE  
CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE  
PHYSICIAN.**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

## Payment Policy

Patients who have an insurance coverage that Raritan Valley Surgical Associates participates with: All co-payments, deductible and/or other balances that are your responsibility, will be due and payable at the time of your office visit.

Patients who have insurance that we do not participate in: It is our policy that all office visit charges are paid at the time of service. If your treatment requires surgery, we will bill your insurance company for the cost of that surgery. You will be billed for the balance after your insurance company has paid. However, if your insurance company does not remit payment after 60 days from the billing, the balance will be due in full from you. Since we are not a party to the agreement with your insurance company, it is not our policy to contact insurance companies to establish why they have not paid. If your insurance company has not paid within 30 days from the date of the billing, we suggest that you contact them immediately. It is your responsibility to pay any deductible or any other balance not paid by your insurance company.

**Patients who are not covered by insurance: We require that you pay for your office visit at the time of your visit.**

**We do not accept Charity Care. If your treatment requires surgery, we will work with you to set up a payment plan that is acceptable to both parties.**

**If I make monthly payments on the balance I owe, I agree to have interest charges added to my monthly balance.**

**“If my delinquent account is sent to a collection agency, I agree to the addition of a collection fee of \$50 or 20% of the balance owed, which ever is greater.”**

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the Practice/Office may contact me/us as described above.

If you have any questions about our payment policy, please feel free to discuss with our billing office.

Please sign and date:

X \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature

Raritan Valley Surgical Associates, P.A.  
The Courtyard  
611 Courtyard Drive  
Hillsborough, NJ 08844  
(908)722-0030

Steeplechase Cancer Center  
30 Rehill Avenue  
Suite 3400  
Somerville, NJ 08876  
(908) 722-0030

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

You may refuse to sign this acknowledgement.

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

I give the following people permission to discuss or to receive any medical documentation from this office.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Please print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I give the right to have messages left on my voicemail at this number:

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

