

Welcome to Our Office

Patient Name _____ Today's Date ____/____/____

Street Address _____ Birthdate ____/____/____

City, State, Zip _____ Sex _____ Age _____

Home Phone # (____) _____ - _____ Social Security Number _____ - _____ - _____

Student _____ (Yes) _____ (No) School _____

Employer _____ Length of Employment _____

Street Address _____ Work Phone # (____) _____ - _____

City, State, Zip _____ Cell Phone # (____) _____ - _____

Name of Spouse _____ Birthdate ____/____/____

Social Security Number _____/_____/_____

Employer _____ Length of Employment _____

Street Address _____ Work Phone # (____) _____ - _____

City, State, Zip _____ Cell Phone # (____) _____ - _____

Emergency Contact _____ Phone # (____) _____ - _____

(Relationship)

Responsible Party if Other Than Patient

Name _____ Home Phone # (____) _____ - _____

Street Address _____ Birthdate ____/____/____

City, State, Zip _____ Sex _____ Age _____

Social Security Number _____ - _____ - _____ Cell Phone # (____) _____ - _____

Employer _____ Length of Employment _____

Street Address _____ Work Phone # (____) _____ - _____

City, State, Zip _____ Cell Phone # (____) _____ - _____

Referring Dr. _____ Phone # (____) _____ - _____

(First) (Last) Fax # (____) _____ - _____

Street Address _____

City, State, Zip _____

Primary Dr. _____ Phone # (____) _____ - _____

Fax # (____) _____ - _____

Pharmacy _____ Phone # (____) _____ - _____

Fax # (____) _____ - _____

Raritan Valley Surgical Associates

Patient History

Patient Name _____ Today's Date ____/____/____

Reason(s) for seeing this physician: _____

Past Medical History: (Please check all disease incurred)

Asthma Heart Disease Rheumatic Fever
 Arthritis Pneumonia Diabetes Allergies: _____
 Cancer Tuberculosis Hepatitis Latex Allergy: _____
 Gastritis Thyroid Disease HIV
 Emphysema (COPD) Peptic Ulcers
 Hypertension Hypercholesterolemia
 Peripheral Vascular Disease Injuries _____
 Coronary Artery Disease

Past Surgical History:

Colon Surgery Appendectomy Breast Surgery
 Cancer Surgery Hernia Surgery Hysterectomy
 Coronary Artery Bypass Vascular Surgery

Other Surgery: _____

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

Cancer Kidney Disease Hemophilia
 Diabetes Allergies Heart Disease
 Other Tuberculosis Arthritis

Do you smoke? _____ How long? _____ How many per day? _____

Please check any pertaining illness you may have:

Skin:	Eyes:	Respiratory:	Cardiovascular:
<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"/> Leg Swelling
<input type="checkbox"/> Ulcer	<input type="checkbox"/> Tearing	<input type="checkbox"/> Last Chest X-Ray	<input type="checkbox"/> Rapid Heart Beat
	<input type="checkbox"/> Blurring Vision		<input type="checkbox"/> Shortness of Breath
Ears:	Head:	Nose:	Throat:
<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 _____

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

Medications:

Aspirin ___ Yes ___ No

Name _____ Dosage _____

Name _____ Dosage _____

Name _____ Dosage _____

Name _____ Dosage _____

Name _____ Dosage _____

Name _____ Dosage _____

Name _____ Dosage _____

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
MULTIPLAN
MAGNACARE
MASTERCARE
MEDICAID
NATIONAL ASSOC LETTER CARRIERS
OXFORD
PHCS
PPO NEXT
QUALCARE
UHC (MEDICAID)
THREE RIVERS
TRI CARE
UNITED HEALTH 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.

Cancellation of appointment

We regret that things may come up. However, we request that if you must cancel or change your appointment that you give us 24hr notice. Otherwise, we may have to charge you for a missed office visit. Thank you for your cooperation.

Patient Name _____ Date _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

INSURANCE ID# _____ GROUP# _____

SUBSCRIBER'S NAME _____

EMPLOYER _____ PHONE # _____

INSURANCE REFERRAL PRIMARY _____ YES _____ NO

CO-PAYMENT PRIMARY \$ _____ DEDUCTABLE \$ _____

SECONDARY INSURANCE

INSURANCE COMPANY _____

CITY, STATE, ZIP _____

INSURANCE ID# _____ GROUP# _____

INSURANCE REFERAL SECONDARY _____ YES _____ NO

CO PAYMENT SECONDARY \$ _____ DEDUCTABLE \$ _____

******IS THIS A WORKERS COMPENSATION CASE? _____ YES _____ NO**

**IF YES, PLEASE NOTIFY THE RECEPTIONIS 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.”

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, N.J. 08844
(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: _____

