

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:

<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"/> 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
<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 \_\_\_\_\_

**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.**

**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: \_\_\_\_\_

