REGISTRATION

Date _____ Home Phone _____ Work Phone _____ Email _____

Patient Last Name _____ First Name _____ Initial _____
Street Address _____
City _____ State _____ Zip _____
Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Social Security # _____ Driver's License # _____
Insured Name _____ How and where did you learn about this clinic? _____
Last Name First Name Initial
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ ☐ Full-time ☐ Part-time City _____ State _____ Zip _____ Years Employed _____
SPOUSE (PARENT)	Name _____ Birthdate _____ SSN: _____ Last Name First Name Initial Employer Name _____ Years Employed _____ Address _____ Phone _____ Occupation _____ City _____ State _____ Zip _____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for?** **Auto Accident ☐ Yes ☐ No Workers Comp ☐ Yes ☐ No** Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician _____ Person to contact in emergency (Name and Phone #) _____ Attorney _____ Telephone: _____ Address _____
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

Name:_____ Today's Date_____

Please answer the following Government Question:

What is your race ☐ Caucasian ☐ Black ☐ Asian ☐ Pacific Islande ☐ Hispanic ☐ Refused to answer

What is your Religion: _____ What is your Native language? _____ Do you smoke? ☐ Y ☐ N

CURRENT HEALTH CONDITION

Reason for Visit (PLEASE BE SPECIFIC) _____

_____

Hospital or doctors seen for this condition _____

_____

When & how did this condition begin (DATE? describe) _____

_____

Are you presently taking any medication ☐ **Yes** ☐ **No** (PLEASE LIST) _____

_____

ALLERGIES: _____

REACTION: _____

PHARMACY NAME_____**City**_____**Telephone #** _____

Please complete insurance information if you are here for:

☐ **WORKER'S COMP INJURY** ☐ **MOTOR VEHICLE ACCIDENT**

Date of Injury _____

Insurance Co. _____ Claim # _____

Address: _____

Name of Adjuster_____

Phone # _____

Name:_____ Date:_____

Medical History

Past Medical History

Please check if you have had any of the following:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bronchitis
- ☐ CAD
- ☐ Cancer Type:_____
- ☐ Cardiovascular Disease
- ☐ CHF
- ☐ Crohn's Disease
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Constipation
- ☐ COPD
- ☐ CRF
- ☐ Other_____
- ☐ CVA
- ☐ Dementia / Alzheimer's
- ☐ Disc Disease
- ☐ DJD
- ☐ Depression
- ☐ DM Type I
- ☐ DM Type II
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fracture
- ☐ GERD
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Implanted Medical Devices
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Nephrolithiasis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Prior MI
- ☐ Pulmonary Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ STD
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Valve Problems

Is there any chance you may be pregnant? ☐ Yes ☐ No

Past Surgical History

Please check if you have had any of the following:

- ☐ No prior surgical history
- ☐ Appendectomy
- ☐ D&C
- ☐ Hysterectomy
- ☐ Knee Arthroscopy
- ☐ Mastectomy
- ☐ Shoulder surgery
- ☐ Spinal Surgery
- ☐ Tonsillectomy
- ☐ Total Knee Replacement
- ☐ Total Hip Replacement
- ☐ Tubal Ligation
- ☐ Other _____

Preventive Care

Have you had any of the following? If so, please provide the date.

- ☐ Last Complete Physical Exam ___/___/___
- ☐ Colonoscopy ___/___/___
- ☐ Flexible Sigmoidocopy ___/___/___
- ☐ PSA ___/___/___
- ☐ Stool Occult Blood ___/___/___
- ☐ Stress Test ___/___/___
- ☐ Routine Eye Exam ___/___/___
- ☐ Dilated Eye Exam ___/___/___
- ☐ Foot Exam ___/___/___
- ☐ HPV
- ☐ Other _____
- ☐ Bone Density ___/___/___
- ☐ Mammography ___/___/___
- ☐ Chlamydia Screening ___/___/___
- ☐ HIV Testing ___/___/___
- ☐ Flu Vaccine ___/___/___
- ☐ Pneumovax ___/___/___
- ☐ Zoster Vaccine ___/___/___
- ☐ Tdap Vaccine ___/___/___
- ☐ TD ___/___/___
- ☐ Tuberculin PPD ___/___/___

General Family History

- ☐ Ankylosing Spondylitis
- ☐ Arthritis
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ CAD
- ☐ MI's
- ☐ CHF
- ☐ Colitis
- ☐ COPD
- ☐ Crohn's Disease
- ☐ CVA / TIA
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ GERD
- ☐ Gout
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ Pulmonary Disease
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ SLE
- ☐ Thyroid Disease

Other _____

THE MARSHALL P. ALLEGRA M.D, LLC

Patient HIPAA Acknowledgment and Consent Form

Patient Name: _____

Date of Birth: _____

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I hereby revoke my request for future communications via email and/or text.

☐ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.*

☐ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*

NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Patient Signature _____ Date _____

Marshall P. Allegra, MD
879 Poole Avenue
Hazlet, NJ 07730
www.allegraortho.com

Privacy Practices Acknowledgment

Acknowledgment Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Date Of Birth:_____

Signature:_____

Date:_____

Poster Compliance Center
SINCE 1991

HIPAA Privacy Notice
(Health Insurance Portability & Accountability Act)

Your Privacy is Important to Us

We value our relationship with you. We respect your right to privacy and we do everything we can to protect the information provided to us on behalf of our customers and our employees. We ask all employees to follow our policies and procedures about customer privacy and information sharing.

We Protect Our Customer's Privacy:

- We restrict access to electronic customer information by using protected passwords when using company information systems.
- We do not leave customer information open or in view at workstations when our employees are not there. We lock up all of our customer files before leaving the workplace.
- We share customer information only with employees as needed to complete service to the customer.

We Protect Our Employee's Privacy:

- Your personal information is only shared with those administering our company health benefits, financial services, or management programs on behalf of all our employees.
- You are exposed to confidential customer information only as it is necessary to provide service to the customer.
- We provide you with required communications about access to your health rights under COBRA (continuation of health coverage) and HIPAA (portability of health coverage and privacy of health information) guidelines.

Your Personal Health Information Rights Are Protected

The Health Insurance Portability and Accountability Act of 1996 helps to protect your rights to health coverage during events such as changing or losing jobs, pregnancy, moving, or divorce, and provides rights and protections for employers when getting and renewing health coverage for their employees. It also covers your rights with respect to protected health information.

"Protected health information" includes any individually identifiable information that is transmitted or maintained in any form or medium that relates to the past, present, or future physical or mental health condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse.

- You have the right to access, inspect and obtain a copy of your protected health information.
- You have the right to amend your protected health information.
- You have the right to request restrictions on uses and disclosures of your protected health information.
- You have a right to an explanation of the legal duties and privacy practices of those who have your protected health information.
- You have the right to receive confidential communications regarding your protected health information.
- You have the right to receive an accounting of disclosures of your protected health information.
- You have a right to file a formal, written complaint with those who have your protected health information, or with the Department of Health & Human Services, if you feel your privacy rights have been violated. You may not be retaliated against for filing a complaint.

These privacy rules are assured under HIPAA (Health Insurance Portability & Accountability Act of 1996) and are enforced by the US Department of Health & Human Services Office of Civil Rights.

US Department of Health & Human Services
Office of Civil Rights, 200 Independence Avenue S.W., Washington D.C. 20201
(877) 696-6775.