Peter M. Corrado, D.O., P.C.

PATIENT INFORMATION FORM

NAME: _____ BIRTH DATE ___/___/___

SEX: M / F MARITAL STATUS: M / D / W / S PHONE: HOME (___) _____

CELL (___) _____ E-MAIL ADDRESS: _____

HOW DO YOU PREFER TO BE CONTACTED:? HOME PHONE ____ CELL ____ E-MAIL ____

ADDRESS: _____
STREET CITY STATE ZIP

EMPLOYER NAME AND ADDRESS: _____

NAME OF **PRIMARY** INSURANCE: _____

INSURED'S NAME, DATE OF BIRTH AND SOCIAL SECURITY NUMBER: _____

_____

NAME OF SECONDARY INSURANCE (IF APPLICABLE): _____

WHO IS SECONDARY INSURED: SELF: ____ SPOUSE: _____ OTHER (RELATIONSHIP) _____

WAS INJURY DUE TO CAR ACCIDENT OR WORK RELATED? YES/NO

PLEASE NOTE: WE DO NOT NORMALLY ACCEPT SUCH CASES, PLEASE CHECK WITH RECEPTIONIST

IF PATIENT IS A MINOR: Mother's Name _____ Father's Name _____

NAME AND PHONE NUMBER OF THE PERSON YOU WOULD LIKE US TO CONTACT IN CASE OF EMERGENCY: _____ WHAT IS THIS PERSON'S RELATIONSHIP TO YOU? (RELATIVE, FRIEND, NEIGHBOR, AGENCY) _____

MAY WE LEAVE PHONE MESSAGES WITH ANYONE IF YOU ARE NOT HOME? YES / NO

IF YES, WHAT IS THEIR NAME AND PHONE NUMBER? _____

_____

PRINT NAME SIGNATURE RELATIONSHIP TO PATIENT (SELF, SPOUSE, PARENT) DATE

NORTH MAIN FAMILY PRACTICE
Peter M. Corrado D.O.
108 North Main Street
Cape May Court House, NJ 08210
(609) 463-9960
Fax (609) 463-9980

CANCELLATION POLICY

As all of our patients are valuable to us, so is our time with them. We ask that appointments be cancelled at least 24 hours prior to the appointment in order to allow other patients to utilize this time. If this policy is not honored a $20 cancellation fee will be added to your account (your insurance will not cover this fee). This fee must be paid before any further appointments can be scheduled. After three no-show appointments, you may no longer be treated in our office.

REFERRALS AND PRESCRIPTIONS

It is the patient's responsibility to request referrals and pick them up in advance of their appointments with specialists. We cannot fax paper referrals and we cannot guarantee the referral will be ready unless it has been requested at least three days in advance.
It is the patient's responsibility to anticipate when prescription refills are needed to give the doctor adequate time to authorize refills.

COPAYS

If your insurance requires a copay, it is due at the time of service. If you request to be billed for your copay a $5.00 processing fee will be assessed. Please note we accept cash or checks.

MEDICAL SERVICES

North Main Family Practice is not responsible if your insurance company does not pay for your doctor visit, lab, x-ray or specialist due to diagnosis or place of service. It is the patient's responsibility to verify insurance regulations. We will do our best to bill procedures, but insurance companies have different rules and it is impossible to know them all.

Patient signature _____ Date _____

Print name _____

GUARANTOR OF ACCOUNT

Please remember that insurance is considered a method of paying for health care costs. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. By your signature below, you hereby agree that it is your responsibility to pay any deductible, co-insurance, co-payment or any other allowed amount not paid for by insurance. Our office is not responsible for inaccurate or incomplete information supplied by you, and you accept full responsibility for payment should you supply us with wrong, incomplete, or false information. In order to control our cost of billing, office co-payments, coinsurance and deductibles are due on the day you are seen.

This will serve as an authorization for Peter Corrado, D.O.. to release medical information to the appropriate fiscal intermediaries as may be necessary to properly file my claim for payment. I/We, the undersigned, promise to be responsible for any balance due and hereby assign all medical and/or surgical benefits, including major medical, to which I am entitled to Peter Corrado, D.O.. if they elect to accept assignment. This includes Medicare, Medicaid, Blue Cross, Champus, Aetna and any other insurance company. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. To assist our office with billing, Peter Corrado, D.O.. utilizes a professional medical billing service to process claims to insurance companies, handle appeals, send patient statements, and other necessary aspects of collecting reimbursement.

If I am not the patient, I certify that I am either the parent or legal guardian of the patient or am authorized to sign on his/her behalf. In the event my insurance fails to remit payment on a timely basis, I hereby assign to Peter Corrado, D.O.. my right to file a formal, written complaint with the appropriate State Department of Insurance(s). I also agree that if this account is sent to a collection agency or assigned to an attorney for collection and/or lawsuit, Peter Corrado, D.O.. shall be entitled to reasonable attorney's fees and other costs of collection.

In addition, for our **Medicare** patients:

I request that payment of authorized Medicare benefits be made to Peter Corrado, D.O.. on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible,, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Signature (patient, parent or guardian) Date

Revised: November 29, 2006

North Main Family Practice
Medical History

Name_____ Date of Birth_____

In case of emergency please contact: _____

(Allergy)	(Reaction)

Surgeries	Date

Check all that apply

Heart Disease		Thyroid : Hyper / Hypo	
Chest Pain		Cancer	
Heart Palpitations		Gastric Disorder	
High Blood Pressure		Kidney Disease	
Stroke		Liver Disease	
Dizziness		Blood Disorder	
Seizures		High Cholesterol	
Headaches / Migraines		Skin Disorder	
Asthma		Lung Disease	
Seasonal Allergies		Diabetes	
Anxiety / Depression		Arthritis	

When was your last:		Family History		Family Member
Mammogram		Cancer		
Dexascan		Hypertension		
Colonoscopy		Diabetes		
Prostate Exam (PSA)		Heart Disease		
Tetanus Shot		Mental Illness		
Pneumonia Shot		Drug/AlcoholAddiction		
Shingles Vaccine		Stroke		
Flu Vaccine		Arthritis		

Social History

Do you smoke		How many cigarettes per day	
Drink Alcohol		How many drinks per week	
Use Illegal Drugs		Explain	
Drink caffeine		How many cups per day	

PETER M. CORRADO, D.O.
NORTH MAIN FAMILY PRACTICE
CAPE MAY COURT HOUSE, NJ 08210
PHONE (609)463-9960

ACKNOWLEDGEMENT FORM

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

Name_____Birthdate_____

Signature_____

Date_____

If you wish to allow another person to receive messages concerning your medical care or to pick up prescriptions or referrals for your care you must provide us with the name and birthdate of that person and sign below giving this medical office permission to do this.

Name_____Birthdate_____

Signature_____Date_____
You may revoke this permission at any time IN WRITING to this office.

NORTH MAIN FAMILY PRACTICE

Peter M. Corrado, D.O.
108 North Main Street, Suite 3
Cape May Court House, NJ 08210
Phone: (609) 463-9960
Fax: (609) 463-9980

I, _____, hereby authorize North Main Family Practice to

Obtain my medical records from: Last Two Years

Previous Physician/Practice: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

Please Mail Records. Do Not Fax.

I understand I may revoke this authorization at any time in writing. If not revoked, this authorization shall remain valid.

Signature of Patient or Legal Representative: _____

Date: _____ Social Security Number: _____

Date of Birth: _____

For Office Use Only

Witness: _____ Date: _____

Wellness Assessment

Name _____ Birth date_____

Date_____

Please help us care for you by answering the following questions.

This document will become part of your confidential medical record.

Do you get exercise?

___often, _____ times per week.

___Occasionally

___ Never

What do you do for exercise? _____

(walking, biking, swimming, etc.)

How would you rate your diet?

__ I try to control fat and calories

__ I don't pay much attention.

__ I am on a specific diet._____

Do you use caffeine?

__ Not usually.

__ Coffee, ___ cups per day.

__ Tea, iced tea, cola ___

Do you drink alcohol?

__ Never

__ I used to, but quit____ (year)

__ Less than once a month

__ Approximately ___ times per week.

Do you use tobacco products?

__ Never

__ I used to, but quit ___ (year)

__ I smoke cigarettes, ___ packs/day

__ I smoke a pipe/cigar or use chewing tobacco.

Do you use illicit drugs?

__ Never
__ I used to, but quit___ (year)
__ Occasionally
__Often

Do you believe you may be at risk for blood borne or sexually transmitted disease?

__ No
__ Risk due to sexual habits or history
__ Risk due to intravenous drug use

When in a motor vehicle, do you wear a seatbelt? __ Yes __ No

Do you use sunscreen?

__ Always
__ Most of the time, when in the sun
__Usually not

Do you use any supplements?

__ Calcium
__ Vitamin E
__ Vitamin C

Other _____
_____
_____

Have you had a tetanus shot in the past ten years?

__ Yes, do you know the date?
__ No
__ Unknown

Have you had your cholesterol tested in the past five years?

__Yes, do you know the date ____
__ No

Have you had a colon cancer screening test?

__ yes, date ____
__ No

Do you have a living will?

__Yes
__ No

Women:

Do you perform a self breast exam?

__ Monthly
__ Occasionally
__ Never

Have you had a mammogram?

__ In the past year
__ Sometime ago____ years.
__ Never

Have you had a pap test?

__In the past year
__ Sometime ago, ___ years
__ Never

Men:

Have you had a PSA (prostate test) in the past year? __ yes, date _____
__ sometime ago: ___ years
__ Never

Do you perform a testicular self exam?

__ Never
__ Occasionally
__ Monthly

We are glad to review any available medical records to help with these questions.

Thank you for completing this personal survey.