Dr. Peter M. Corrado, DO, PC
North Main Family Practice
108 Mechanic Street, Cape May Court House, NJ 08210
Phone 609-463-9960 *** Fax 609-463-9980
drpetercorrado.com *** drpetercorrado@gmail.com

PATIENT INFORMATION FORM

NAME:____ BIRTH DATE ____/____/________

SEX: M / F MARITAL STATUS: M / D / W / S EMAIL ___________________________________

PHONE: HOME___________________ CELL_____________________ OTHER_______________

ADDRESS: ____
STREET CITY STATE ZIP

OTHER ADDRESS: ____
STREET CITY STATE ZIP

EMPLOYER NAME AND ADDRESS____

IF PATIENT IS A MINOR: MOTHER'S NAME_____________________ FATHER'S NAME _______________

PRIMARY INSURANCE ______________________________#______________________________

INSURED'S NAME, DATE OF BIRTH, SOCIALSECURITY_____________________________

____

SECONDARY INSURANCE (IF APPLICABLE)____

WAS THE INJURY DUE TO A MOTOR VEHICLE ACCIDENT? Y / N WORK RELATED? Y / N
*** PLEASE NOTE: WE DO NOT NORMALLY ACCEPT SUCH CASES, PLEASE CHECK WITH THE RECEPTIONIST***

IN CASE OF AN EMERGENCY CONTACT: RELATIONSHIP______________________________

NAME__________________________________NUMBER______________________________

MAY WE LEAVE A PHONE MESSAGE WITH ANYONE IF YOU ARE NOT HOME? Y / N

NAME__________________________________NUMBER______________________________

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

NORTH MAIN FAMILY PRACTICE

MEDICAL HISTORY

NAME____ DATE OF BIRTH_________

ALLEGRY REACTION

ALLERGY	REACTION

SURGERIES	DOCTOR	DATE

CHECK ALL THAT APPLY:

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

WHEN WAS YOUR LAST:

Mammogram ________
Dexascan ________
Colonoscopy ________
Prostate Exam-PSA ________
Tetanus Shot ________
Pneumonia Shot ________
Shingles Vaccine ________
Flu Vaccine ________
Covid-19 Vaccine ________

FAMILY HISTORY FAMILY MEMBER

Cancer____
Hypertension___________________________________
Diabetes______________________________________
Heart Disease__________________________________
Mental Illness__________________________________
Drug / Alcohol Addiction__________________________
Stroke____
Arthritis______________________________________
Other____

SOCIAL HISTORY:

Smoke Cigarettes Y / N How many per day _______ Began smoking at age _______________
Vape or use E-Cigarettes Y / N How often __________ Began Using at age_________________
Drink Alcohol Y / N How many drinks per day ____________ Per week __________________
Use Illegal or "Recreational" Drugs Y / N Comments______________________________________
Drink Caffeinated Beverages Y / N How many cups/glasses per day _______________________
Exercise Y / N Type_________________________ Frequency_____________________________
Special Diet Y / N Comments____
Do you take any supplements Y / N ____
Do you believe you are at risk for a blood borne or sexually transmitted disease Y / N _____________
Do you perform self exams? Breast Y / N Testicular Y / N ___________________________________
Do you wear a seatbelt while in a motor vehicle? Y / N ___________________________________
Do you use sunscreen ___ Always ___ Most of the time, when in the sun. ___ Usually not

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

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 visit co-payments, coinsurance, deductibles, and outstanding balances are due on the day you are seen.

This will serve as an authorization for Peter M. Corrado, DO, 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 M. Corrado, DO, if they elect to accept the assignment. This includes Medicare, Blue Cross, Aetna, Amerihealth, Horizon, 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 M. Corrado, DO 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 M. Corrado, DO, 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 M. Corrado, DO 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 M. Corrado, DO 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 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 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, coinsurance, 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

Peter M. Corrado, D.O.
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(609)463-9960 phone
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ACKNOWLEDGEMENT FORM

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

Name____ Birth date_____________________

Signature____ Date_________________________

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

Name____ Birth date_____________________

Name____ Birth date_____________________

Name____ Birth date_____________________

Signature____ Date ________________________

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

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I, ____, hereby authorize North Main Family Practice to

Obtain Medical records

Name of Patient____Date of Birth _____________

Previous Physician/ Practice____

Address ____

Phone ____

Fax ____

I understand that this authorization shall be used to obtain my records from those providers involved in my treatment while I am a patient with North Main Family Practice.

*** PLEASE MAIL IF MORE THAN 40 PAGES ***

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

Signature (Self, Parent, Legal Guardian*) ____

Date: _____________________

*Please provide Medical Power of Attorney documentation