





**Insurance Release**

I hereby authorize my insurance benefits to be paid directly to St. Barnabas Medical Center, realizing I am responsible for non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers.

I realize that I am solely responsible for negotiating disputes with insurance companies.

I agree to pay all charges for services rendered by St. Barnabas Medical Center, which are not covered by my insurance benefits. If it becomes necessary for St. Barnabas Medical Center to seek action to enforce the above agreement, I agree to pay all collection fees and all attorney's fees for such action.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The individual signing is:

\_\_\_\_\_ The Patient

\_\_\_\_\_ Power of Attorney

\_\_\_\_\_ Guardian

\_\_\_\_\_ Other. Please specify relationship: \_\_\_\_\_



**Acknowledgement of Receipt**  
**Notice Of Privacy Practices**

A Notice of Privacy Practices was provided and given to me. It has a description of information uses and disclosures. I acknowledge receipt of the notice and I understand that St. Barnabas Medical Center reserves the right to change its notice and practices and that prior to those changes a copy of the revised notice will be made available to me.

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

The individual signing is:

\_\_\_\_\_ The Patient

\_\_\_\_\_ Power of Attorney

\_\_\_\_\_ Guardian

\_\_\_\_\_ Other. Please specify relationship: \_\_\_\_\_



**Consent for Diagnosis and Treatment**

**Patient Name:** \_\_\_\_\_

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

I, \_\_\_\_\_, am presenting myself for diagnosis and treatment in the ambulatory health facilities of St. Barnabas Medical Center and I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment by authorized agents and/or employees of the facilities, their medical staff or designees as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of any such examinations or treatment, and I understand any special procedure or treatment involving appreciable risk will be explained to me by a physician and that I may at any time refuse such treatment.

My signature below constitutes:

1. My acknowledgement that I have read, understand and agree to the foregoing.
2. That I hereby give authorization and consent.

\_\_\_\_\_  
**Witness to signature**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

Complete the following if applicable:

Patient is a minor or is unable to consent because: \_\_\_\_\_.

\_\_\_\_\_  
**Witness to signature**

\_\_\_\_\_  
**Signature of Responsible Party**

\_\_\_\_\_  
**Relationship**



**NEW PATIENT REFERRAL FORM**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Zip Code (For tracking purposes): \_\_\_\_\_

How did you hear about St. Barnabas Medical Center?

- \_\_\_\_\_ TV Ad?
- \_\_\_\_\_ Website?
- \_\_\_\_\_ Radio Ad?
- \_\_\_\_\_ Yellow Pages?
- \_\_\_\_\_ Magazine?
- \_\_\_\_\_ Newspaper?
- \_\_\_\_\_ Billboard?
- \_\_\_\_\_ Insurance Company?
- \_\_\_\_\_ Direct mailing/Welcome Wagon?
- \_\_\_\_\_ Friend/Family?
- \_\_\_\_\_ Other Professional?
- \_\_\_\_\_ St. Barnabas Health System Employee?

Who can we thank for referring you? \_\_\_\_\_

Are you a resident of St. Barnabas Health System? \_\_\_\_\_

If yes, which location? \_\_\_\_\_

Are you an employee of St. Barnabas? \_\_\_\_\_

A family member of an employee? \_\_\_\_\_

Is this a work physical? \_\_\_\_\_

If yes, for what company? \_\_\_\_\_

**Thank you for taking the time to complete our patient information packet and welcome to St. Barnabas Medical Center.**



**PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS**

Please circle if you have had problems with or are presently complaining of any of the following:

- |                         |                                  |
|-------------------------|----------------------------------|
| 1. High blood pressure  | 27. Change in bowel habits       |
| 2. Diabetes             | 28. Diarrhea                     |
| 3. Neuropathy           | 29. Irritable Bowel Syndrome     |
| 4. Retinopathy          | 30. Hemorrhoids                  |
| 5. Cancer _____         | 31. Blood in stool               |
| 6. Heart Disease        | 32. Constipation                 |
| 7. Chest pain/tightness | 33. Frequent urination           |
| 8. Shortness of breath  | 34. Difficulty urinating         |
| 9. Palpitations         | 35. Kidney disease               |
| 10. Lightheadedness     | 36. Abdominal discomfort         |
| 11. Headache            | 37. Indigestion/Heartburn/GERD   |
| 12. Asthma              | 38. Nausea                       |
| 13. Bronchitis          | 39. Vomiting                     |
| 14. Pneumonia           | 40. Ulcer                        |
| 15. Persistent cough    | 41. Gallbladder disease          |
| 16. Hay fever/allergies | 42. Colitis                      |
| 17. T.B.                | 43. Hepatitis or jaundice        |
| 18. Arthritis           | 44. Unexplained weight loss/gain |
| 19. Low back pain       | 45. Alcohol abuse                |
| 20. Gout                | 46. Tobacco abuse                |
| 21. Skin disease        | 47. Drug abuse                   |
| 22. Thyroid disease     | 48. Venereal disease             |
| 23. Swollen limbs       | 49. Anxiety                      |
| 24. Blood disorder      | 50. Depression                   |
| 25. Anemia              | 51. Memory loss/dementia         |
| 26. Osteoporosis        | 52. Other: _____                 |

**FAMILY HISTORY**

Has any member of your family, including parents, grandparents and siblings, ever had any of the following?

	<b>Family Member</b>	<b>Age of Onset</b>
Cancer (describe type)	_____	_____
Hypertension	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Mental disease	_____	_____
Drug or alcohol addiction	_____	_____
Other	_____	_____
Other	_____	_____
Other	_____	_____
Other	_____	_____

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**OPERATIONS AND HOSPITALIZATIONS-Please list reason and date**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMMUNIZATION HISTORY-Please list last date given.**

	Date		Name	Date
Tetanus	_____	Other	_____	_____
Pneumonia	_____	Other	_____	_____
Hepatitis	_____	Other	_____	_____
Influenza	_____	Other	_____	_____

**HEALTH HABITS**

Do you drink caffeine? If so, how much/often? \_\_\_\_\_

Do you use tobacco? If so, how much/often? \_\_\_\_\_

Do you drink alcohol? If so, how much/often? \_\_\_\_\_

Do you use recreational drugs? If so, how much/often? \_\_\_\_\_

Do you practice safe sex? Yes \_\_\_\_\_ If no, why not? \_\_\_\_\_

Do you wear seatbelts? Yes \_\_\_\_\_ If no, why not? \_\_\_\_\_

Do you wear a bike helmet? N/A \_\_\_\_\_ Yes \_\_\_\_\_ If no, why not? \_\_\_\_\_

Is there a gun in your home? N/A \_\_\_\_\_ If yes, is it out of children's reach? \_\_\_\_\_

Have you ever worked with chemicals, paints asbestos or other hazardous materials?  
If yes, please explain: \_\_\_\_\_

Are you in a relationship in which you have been physically hurt by your partner? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have a living will? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a donor card? Yes \_\_\_\_\_ No \_\_\_\_\_

**FOR MEN ONLY**

Date of last prostate exam \_\_\_\_\_ Any history of abnormalities? \_\_\_\_\_

Date of stool last checked for blood \_\_\_\_\_ Any history of abnormalities? \_\_\_\_\_

Date of last colonoscopy \_\_\_\_\_ Any history of abnormalities? \_\_\_\_\_

**FOR WOMEN ONLY**

Date of last pap smear \_\_\_\_\_ Any history of abnormalities? \_\_\_\_\_

Date of last breast exam \_\_\_\_\_ Any history of abnormalities? \_\_\_\_\_

Date of last mammogram \_\_\_\_\_ Any history of abnormalities? \_\_\_\_\_

Date of last bone density study \_\_\_\_\_ Any history of abnormalities? \_\_\_\_\_

Date of last colonoscopy \_\_\_\_\_ Any history of abnormalities? \_\_\_\_\_

Date of stool last checked for blood \_\_\_\_\_ Any history of abnormalities? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Age at onset of period \_\_\_\_\_ Frequency \_\_\_\_\_ Length \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_

Prolonged abnormal bleeding? If so, please describe \_\_\_\_\_

Abnormal vaginal/nipple discharge? If so, please describe \_\_\_\_\_