ST. BARNABAS MEDICAL CENTER

PATIENT REGISTRATION (PLEASE PRINT)

IS YOUR ILLNESS/INJURY THE RESULT OF AN AUTOMOBILE ACCIDENT? _____ONSET DATE:_____

IS YOUR ILLNESS/INJURY THE RESULT OF A WORK RELATED ACCIDENT?_____ONSET DATE:_____

GENERAL INFORMATION

Patient Name:_____
First Middle Initial Last

Home Telephone:_____ Cell Phone:_____

Patient Address: _____
Number Street Apt. # City State Zip

Age:_____ Date of Birth:_____ Social Security No:_____

Please Circle: Sex: Male Female Marital Status: Single Married Divorced Widowed

Employed By:_____ Work Telephone:_____

INSURANCE COVERAGE: Please present insurance card(s) with completed registration form

Primary Insurance:_____ ID#_____Grp#_____

Name of Policy Holder:_____Birthdate of Policy Holder _____

Name of Employer:_____

Secondary Insurance:_____ID#_____Grp#_____

Name of Policy Holder:_____Birthdate of Policyholder:_____

EMERGENCY CONTACT INFORMATION

Person to contact:_____Telephone:_____

Relationship to patient:_____

POWER-OF-ATTORNEY OR OTHER RESPONSBILE PARTY

Name:_____ Relationship:_____

Address:_____
Number Street Apt. # City State Zip

Home Telephone:_____Work Telephone:_____Cell:_____

Would you like to receive reminders and special events via email?
Please note that no confidential information will be transmitted.
If so, please provide email address: _____ Date: _____

ST. BARNABAS MEDICAL CENTER

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. It if 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: _____

ST. BARNABAS MEDICAL CENTER

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: _____

ST. BARNABAS MEDICAL CENTER

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

ST. BARNABAS MEDICAL CENTER

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Please check one option)

☐ I _____ decline authorization for the use and disclosure of protected health information (PHI) about me to anyone outside of the professional medical community for which I am obtaining treatment.

☐ I authorize the individual(s) listed below to obtain certain protected health information (PHI) about me. Please fill in below name(s) of individual(s) and sign at the bottom.

I authorize St. Barnabas Medical Center to use and disclose certain protected health information (PHI) about me to:

_____	_____	_____
Name of entity to receive this information	Relationship	Telephone number(s)
_____	_____	_____
Name of entity to receive this information	Relationship	Telephone number(s)
_____	_____	_____
Name of entity to receive this information	Relationship	Telephone number(s)

This authorization permits St. Barnabas Medical Center staff to use and/or disclose individually identifiable health information regarding treatment, test results, appointments, telephone conversations with physicians and office staff, consultant evaluation and treatment to the above specified individual for the purpose of maintaining optical medical treatment.

If requested by the patient, the purpose of this request may be listed as “at the request of the individual”. This purpose is so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____. (Please write in an actual date. Most patients use 2-10 years).

I have the right to revoke this authorization in writing. My written revocation must be submitted to the medical office staff at: **St. Barnabas Medical Center, 5830 Meridian Road, Gibsonia, PA 15044.**

Signature of Patient or Legal Guardian _____

Print Name of Patient or Legal Guardian _____

Relationship to Patient _____

Date: _____

ST. BARNABAS MEDICAL CENTER

NEW PATIENT REFERRAL FORM

Patient Name:_____Date:_____

Zip Code (For tracking purposes):_____

How did you hear about St. Barnabas Medical Center?

_____TV Ad?
_____Website?
_____Internet search? If yes, which search engine? _____
_____Radio Ad?
_____Yellow Pages?
_____Advertisement? If yes, which publication? _____
_____Magazine?
_____Newspaper?
_____Billboard?
_____Insurance Company?
_____Direct mailing?
_____Friend/Family?
_____Other Professional?
_____St. Barnabas Health System Employee?
_____Personal visit from medical center staff member?

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? _____

Thank you for taking the time to complete our patient information packet.
Welcome to St. Barnabas Medical Center!

ST. BARNABAS MEDICAL CENTER

MEDICAL HISTORY **Date:** _____

Name: _____ **Age:** _____ **Birthdate:** _____

ALLERGIES-Please list medications and/or substances along with type of reaction **NONE** ☐

_____

_____

_____

MEDICATIONS-Please list prescription, over-the-counter, vitamins and herbal supplements

Medication	Dosage	How many times a day?

Pharmacy Name/Location: _____

Pharmacy Telephone Number: _____

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

FAMILY HISTORY

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

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

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 _____