D.C. Medical Care LLC

Patient Intake Form

Patient Information

Last Name _____ **First Name** _____ **Middle Initial** _____

Date of Birth _____ **Social Security Number** _____

Home Address _____ **Apartment #** _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Email Address _____ **Language** (other than English) _____

Gender ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed ☐ Life Partner ☐ Other

Race ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ White ☐ Other

Emergency Contact

Last Name _____ **First Name** _____

Phone Number _____ **Email Address** _____ **Relation to Patient** _____

Employment Information

Employment Status ☐ Employed (Full/Part Time) ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed ☐ Other

Employer _____ **Occupation** _____

Employer Address _____

City _____ **State** _____ **Zip** _____

Insurance Information

Name of Insured _____ **Relation to Patient** _____

Date of Birth _____ **Social Security #** _____

Primary Insurance _____ **ID #** _____ **Group ID #** _____

Secondary Insurance _____ **ID #** _____ **Group ID #** _____

Pharmacy Information

Pharmacy Name _____ **Phone #** _____ **Fax #** _____

Address _____

City _____ **State** _____ **Zip** _____

266 Harristown Road, Suite 305 ♦ Glen Rock, New Jersey 07452
(201) 475-9421 ♦ Fax: (201) 475-1555 ♦ DCmedical@gmail.com ♦ DCmedicalcare.com

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process claims from DC Medical Care, LLC. I permit a copy of this authorization to be used in place of an original.

Date: _____ Signature: _____

I hereby authorize DC Medical Care, LLC to apply for benefits on my behalf for covered services rendered or ordered by the practice and request that the ayment from my insurance be made directly to DC Medical Care, LLC. I certify that the information I have reported in regards to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either insurance company at any time in writing.

Date: _____ Signature: _____

Consent for Treatment

I, _____, hereby give permission to DC Medical Care, LLC staff to provide diagnostic and treatment services for me and recommendations for further treatment. I understand that I have the right to accept or decline all or part of the recommended treatment after the risks, benefits, and alternatives have been explained to me. I will be provided with explicit consent for invasive procedures.

Receipt Notice of Privacy Practice Written Acknowledgement Form

I, _____, have read a copy of DC Medical Care, LLC Notice of Privacy Practice/Patient Bill of Rights (attached, for reference, at the end of this form).

Date: _____ Signature: _____

Medical History Form

Your answers on this form will help us understand your medical conditions better. If you are uncomfortable with any questions, do not answer it. Best estimates are fine if you cannot remember specific details.

Personal Medical History

Please indicate if you have had any of the following problems currently or in the past.

Anemia	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Kidney disease/stones	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No	Liver disease/Hepatitis	☐ Yes	☐ No
Cancer/tumors	☐ Yes	☐ No	Lung disease/pneumonia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Skin disease	☐ Yes	☐ No
- If yes, what age?			Sleep apnea	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Thyroid disease/Goiter	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Ulcers(stomach or intestinal)	☐ Yes	☐ No

If Yes to any of the above, please elaborate if necessary. _____

_____

_____

When was your last Tetanus shot? _____

Family Medical History

☐ Adopted, Family History Unknown

Please indicate if anyone in your family(grandparents, parents, brothers, sisters, or children) have had any of the following conditions?

			Family Relationship
Alcoholism	☐ Yes	☐ No	_____
Anemia	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Bowel/Colon Cancer	☐ Yes	☐ No	_____
Breast Cancer	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Heart Disease/Angina	☐ Yes	☐ No	_____
High Cholesterol	☐ Yes	☐ No	_____
Kidney Disease	☐ Yes	☐ No	_____
Thyroid Disorder	☐ Yes	☐ No	_____
Other?			_____

Medications

Please list all your current medications, including medications/supplements not needing a prescription:

Medication	Dose and Directions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Allergies

Please list any allergies or reactions to medications:

Allergen	Dose and Directions

Operations

Have you had any operations? If yes, list:

Type of operation/Reason for operation	Hospital/Facility	Date of operation

Personal Habits

Tobacco Use

Cigarettes: ☐ Never ☐ Quit-Date_____ ☐ Current Smoker: Packs a Day_____ , # of years _____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes, average # of drinks per week _____
If no, have you in the past? ☐ No ☐ Yes

Drug Use

Do you use any recreational drugs such as marijuana, cocaine, stimulants, narcotics, diet pills?
☐ Yes ☐ No
Have you ever used needles? ☐ Yes ☐ No

Sexuality

Are you sexually active? ☐ Yes ☐ No ☐ Not Currently
Birth Control Method _____

Referral

Where did you hear about us?
☐ Google Search ☐ ZocDoc ☐ Friend (Name, so we can thank them: _____)
☐ Other _____

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Acknowledgement of Financial Responsibility and Office Policies

Our physician and staff are dedicated to assisting you to make sure that your health insurance has all of the information necessary to reimburse for all covered services. Your health insurance may not pay for all of your health care costs; you, your employer and your insurance company largely determine your health benefits. Health insurance only pays for covered items and services when their rules are met.

Insurance Coverage

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, you will be responsible for payment.

Co-payments, CO-Insurance, and Deductions

- Co-insurance and co-payments are the patient's/guarantor's responsibility. Co-payments are due at the time of the visit. For your convenience we may accept payment in the form of cash, checks and credit cards. A charge of $20 will have to be paid if you do not have your co-pay at the time of your visit.
- Deductibles are the patient's/guarantor's responsibility. The deductible is determined by the contract you have with your health insurance carrier at the time of the visit. If it is not yet fulfilled $70 has to be paid toward it.

No Show

- DC Medical Care, LLC has a no-show policy. Kindly cancel or reschedule your appointment at least 48 hours prior to your appointment. If you are scheduled for an appointment and do not cancel or reschedule within 48 hours, a letter will be sent to you for a charge of $50.

Insurance Requests

- You are responsible for responding to insurance company requests for further information. Also, you are responsible to select Dr. Dana Cernea as your primary care physician by notifying your insurance company.

Insurance Payments

- Any insurance payments sent to you should be forwarder to our Billing Office with a copy of the explanation of benefits (EOB) received.

_____	_____	_____
Print Name	Signature	Date

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Acknowledgement of Receipt of Notice of Privacy Practices & Consent/Limited Authorization and Release Form

The HIPAA Privacy Rule requires health care providers to develop and distribute a notice that provides a clear, user friendly explanation of individuals rights with respect to their personal health information and the privacy practices of our practice.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be effective as the original.

My signature will also serve as a PHI document release should I request treatment or rediographs be sent to other doctors or facilities in the future.

I authorize **information about my health** to be conveyed via:

- ☐ Cell Phone
- ☐ Home Phone
- ☐ Work Phone
- ☐ E-mail
- ☐ All of the above

By signing this form you are granting consent to our practice, DC Medical Care, LLC to use and disclose your protected health information for the purposes of treatment and health care operations.

I hereby authorize DC Medical Care, LLc to discuss my care and/or test results with the following people (not including other health personnel such as specialists, third party payers, etc.):

1. _____ Phone Number: _____
2. _____ Phone Number: _____

Patient Name _____Signature of Patient _____

Patient Bill of Rights

- The patient has the right to considerate and respectful care.
- The patient has the right to obtain from this physician complete and current information and medical records concerning their diagnosis, treatment, and prognosis in terms the patient can reasonably expect to understand.
- The patient has the right to receive from the physician information necessary to give informed consent prior to the start of any procedure and/or treatment.
- The patient has the right to refuse treatment and to be informed of the medical consequences of this action.
- The patient has the right to every consideration of their privacy concerning their own medical care program.
- The patient has the right to expect that all communications and records pertaining to their care should be treated as confidential and that no information is shared unless given explicit permission.
- The patient has the right to expect within its capacity; the practice must take reasonable response to the request of a patient for service.
- The patient has the right to obtain information as to any relationships this practice has to other health care providers, hospitals and educational institutions insofar as their care is concerned.
- The patient has the right to be advised if the practice proposes to engage in or perform human experimentation affecting their care or treatment.
- The patient has the right to expect reasonable continuity of care.
- The patient has the right to examine and receive an explanation of their bill.
- The patient has the right to know what practice rules and regulations apply to their conduct as a patient.

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