PATIENT INFORMATION FORMS

Today's date: _____

Patient's name: _____ Date of Birth : _____

Street address: _____ Apt# _____

City: _____ State: _____ Zip code: _____

Home # _____ Cell # _____

Social Security # _____ Email address: _____

Pharmacy Name & Address: _____

Race: American Indian/Alaskan Native
Asian
Black/African American
Native Hawaiian
White

Ethnicity: Hispanic/Latino
Non-Hispanic

Primary Language: _____

Place of employment: _____ Work # _____
Address: _____
City: _____ State: _____ Zip code: _____

Marital status: Single Married Divorced Widowed

Emergency contact: _____ Phone # _____

Primary Physician: _____ Phone # _____

Referring physician: _____ Phone # _____

What's the reason for your visit today?

_____

Did the injury occur at work? *YES NO*

I understand that I am financially responsible for all charges of services rendered to me including the balance remaining after payment of possible insurance benefits.

Signature _____ Date _____

Assignment of benefits- I authorize payment of medical benefits to Dr. Iannuzzi for professional services rendered.

Signature _____ Date _____

Release of information- I authorize the release of any medical information necessary to process claims

Signature _____ Date _____

Health History

To help us meet all your healthcare needs, please complete this entire form. This is a confidential record of your medical history and will be kept in the office. Feel free to ask us any questions you may have.

Please list all the current medications you are taking (include all non-prescription drugs)

_____

_____

_____

_____

Describe all serious accidents, severe injuries, head injuries, fractures, and/or broken bones. Please include dates.

_____

_____

_____

Please list any allergies you have (food, medications, etc.)

_____

_____

Smoking: ◯ Former ◯ Current ◯ Non-Smoker

Usual weight: _____ **Height:** _____

Past or current medical history:

Arthritis NO_____ YES_____
Epilepsy NO_____ YES _____
Tuberculosis NO_____ YES _____
Diabetic NO_____ YES_____
If YES: shoe size_____ last A1C _____
Cancer NO _____YES _____
High or low blood pressure NO _____ YES _____
Asthma NO_____ YES_____
AIDS/HIV NO_____ YES_____
Stroke NO_____ YES_____
Hepatitis A, B, C NO _____ YES _____
Ulcer NO _____ YES_____
Cholesterol NO _____ YES_____

Any other disease? NO _____ YES _____

If yes please list: _____

Signature: _____ **Date:** _____

Insurance information

Primary Insurance:

Health Insurance Company:

_____Policy ID#_____

Subscriber/Policy Holder information:
(Applies to whom are not the primary policy holder)

Name: _____

Address: _____

DOB: _____

Social security number:_____

Telephone: _____

Place of employment:_____

Signature:_____ Date: _____

Secondary insurance

Health Insurance Company:

_____ Policy ID#_____

Subscriber/Policy holder information:
(Applies to whom are not the primary policy holder)

Name: _____

Address: _____

DOB: _____

Social security number:_____

Telephone: _____

Place of employment: _____

Signature: _____ Date: _____

Dr. Peter Iannuzzi
7817 Bergenline Avenue
North Bergen, NJ 07047

Office Policy

The following is our office policy. If there are any questions concerning these terms, please do not hesitate to ask.

1. All returned checks for any reason will be charged the amount of the check plus an additional $35.00

2. All bills must be paid in full within 90 days. Any outstanding balances after 90 days will carry out an interest of 1.5% monthly until balance is paid.

3. Any outstanding balance which requires us to use an attorney, collection agency, or becomes a court matter will have additional charges added to their outstanding balance.

4. The first forms presented by the patient will be free of charge thereafter a fee of $25.00 per form will be charged.

5. All referrals are the patient or patient's guardian responsibility.

6. Copies of records require at least a two week notice.

   a. Search fee..... $15.00
   Per page.....$1.00
   b. X-Ray fee.....$5.00

Signature: _____ Date: _____

We are here to help you, please let us know if you have any questions or concerns.