SPECIALTY SURGICAL ASSOCIATES

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STEVEN J. BINENBAUM, M.D., F.A.C.S., F.A.S.M.B.S
PAUL A. KOLARSICK, M.D.

10 Industrial Way East, Eatontown, NJ 07724 - Tel: 732-389-1331 – Fax: 732-542-8587

PATIENT INFORMATION (PART I)

--- PLEASE PRINT ALL INFORMATION ---

Last Name: ______________ First Name: ______________ MI___ ☐Male☐Female

Address: ______________ City: ______________ State: ____ Zip: ________

Date of Birth: ______/______/______ Age: ______ SS#: ________-______-________ Marital Status: ______

Home Phone #: ______________ Work Phone # or other phone # **(Required):** ______________

Employer (Name & Address) ______________

Name of Spouse / Emergency Contact: ______________

Referring Physician (Name, Address & Phone #): ______________

Primary Care Physician: Name, Address & Phone # **(Required)** / **Cardiologist:**

____

Pharmacy & Phone #: ______________ **Personal Email Address:** ______________

INSURANCE INFORMATION: PLEASE GIVE US YOUR CARD TO PHOTOCOPY

CO-PAYMENTS ARE DUE AT THE TIME OF VISIT

Primary Carrier: ______________ ID#: ______________

Subscriber's Name: ______________ Date of Birth: ______________

Secondary Carrier: ______________ ID#: ______________

Subscriber's Name: ______________ Date of Birth: ______________

I HEREBY AUTHORIZE C.J. SPECIALTY SURGICAL ASSOCIATES TO FURNISH INFORMATION CONCERNING MY ILLNESS AND TREATMENT TO THE INSURANCE CARRIERS. I ALSO HEREBY ASSIGN C.J. SPECIALTY SURGICAL ASSOCIATES PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

☒ ______________________________ ______________

SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF MINOR) DATE

* ONLY IF AUTO RELATED: COMPLETE INFORMATION BELOW

Date of Accident: ______________ Auto Related: [ ] Job Related: [ ]

Claim #: ______________ Adjuster: ______________ Phone #: ______________

Insurance Company - Name & Address: ______________

FOR WORKER'S COMPENSATION AND NO FAULT CASES, IF PAYMENT IS NOT RECEIVED WITHIN SIX MONTHS I AM RESPONSIBLE FOR FULL PAYMENT TO THE PHYSICIAN.

____

SIGNATURE OF PATIENT (RESPONSIBLE PARTY, IF MINOR)

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PATIENT MEDICAL HISTORY (PART II)

--- PLEASE PRINT ALL INFORMATION ---

Last Name: ______________________ First Name: ______________________ Date: __________

REASON FOR VISIT: (Check Below) **Date of First Symptom:** ______________

[ ] Hernia
[ ] Ulcer
[ ] Pilonidal Cyst
[ ] Gallbladder
[ ] Other (Specify) ______________________

[ ] Lymph Nodes
[ ] Cyst
[ ] Gastric Problems
[ ] Abdominal Pain

[ ] Rectal Bleeding
[ ] Colonoscopy
[ ] Hemorrhoids
[ ] Anal/Rectal Pain

PATIENT HISTORY:

Hypertension [ ] Yes [ ] No **Diabetes** [ ] Yes [ ] No **Heart Disease** [ ] Yes [ ] No **Asthma** [ ] Yes [ ] No
Stroke [ ] Yes [ ] No **HIV**[ ] Yes [ ] No
Hepatitis [ ] Yes [ ] No **High Cholesterol** [ ] Yes [ ] No
Cancer [ ] Yes [ ] No (specify type) ______________________
Other (Specify) ______________________

DID YOU HAVE A COLONOSCOPY? [ ] Yes [ ] No **Date of your Last Colonoscopy** ______________

WEIGHT __________ HOW LONG HAVE YOU BEEN AT THIS WEIGHT __________ HEIGHT__________

DO YOU USE TOBACCO NOW? [ ] Yes [ ] No **IN THE PAST?** [ ] Yes [ ] No **DAILY AMOUNT USED** __________ **HOW MANY YEARS** __________

DID YOU EVER CHEW TOBACCO? [ ] Yes [ ] No

ALCOHOL USE: [ ] Yes [ ] No Frequency: [ ] Daily [ ] Occasional

ARE YOU ALLERGIC TO LATEX? [ ] Yes [ ] No **ARE YOU ALLERGIC TO PENICILLIN?** [ ] Yes [ ] No

ALLERGIES TO MEDICATIONS: ______________________

LIST OF CURRENT MEDICATIONS (Dosage and Frequency):

PREVIOUS SURGERIES (Dates, Hospitals and name of Surgeon):

Do you have an Advanced Directive? (Living Will) *[ ] Yes [ ] No*

FAMILY HISTORY:

[ ] **Cancer** (Specify type and family member) ______________________
[ ] **Arthritis** [ ] **Stroke** [ ] **Heart Disease** [ ] **Kidney Disease** [ ] **Diabetes**
[ ] **Other** (Specify) ______________________

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PATIENT MEDICAL HISTORY (Part III)

--- PLEASE PRINT ALL INFORMATION ---

Last Name: ______________________ First Name: ______________________ Date__________

REVIEW OF SYSTEMS: *(Indicate below all that apply to you on a regular basis)*

General:	[ ] Night Sweats	[ ] Fever	[ ] Poor Appetite	[ ] Weight Loss	[ ] Fatigue [ ] Malaise
Eyes:	[ ] Redness	[ ] Itching	[ ] Blurriness	[ ] Double Vision	[ ] Blindness
ENT:	[ ] Ringing in ears	[ ] Sinusitis	[ ] Hearing Loss	[ ] Hoarseness	[ ] Difficulty Swallowing
Heart:	[ ] Palpitations	[ ] Angina	[ ] Chest Pain	[ ] Swollen Ankles	
Lungs:	[ ] Frequent Cough	[ ] Wheezing	[ ] Coughing Blood	[ ] Pain w/Breathing	[ ] Difficulty Breathing
GI:	[ ] Abdominal Pain	[ ] Constipation	[ ] Nausea/Vomiting	[ ] Blood in Stool	
	[ ] Heartburn	[ ] Diarrhea	[ ] Rectal Bleeding		
GU:	[ ] Pain w/Urination	[ ] Frequent Urination	[ ] Blood in Urine	[ ] Difficulty w/Urination	
Ortho:	[ ] Arthritis	[ ] Chronic Back Pain		[ ] Swollen Joints	
Skin:	[ ] Ulcerations	[ ] Hair Loss	[ ] Infections	[ ] Psoriasis	[ ] Rash
Neuro:	[ ] Slurred Speech	[ ] Weakness	[ ] Migraines	[ ] Fainting	[ ] Seizures
Psych:	[ ] Mood Disorder	[ ] Depression	[ ] Insomnia	[ ] Anxiety	[ ] Agitation
Endo:	[ ] Weight Gain	[ ] Excessive Sweating		[ ] Excessive Thirst	[ ] Intolerance Heat/Cold
Heme:	[ ] Bruising	[ ] Bleeding	[ ] Phlebitis	[ ] Swollen Lymph Nodes	
Immune:	[ ] Skin Reactions	[ ] Allergies/Seasonal		[ ] Hives	[ ] Frequent Urination

Have you had a pneumonia vaccine in the last 5 years? __________

Have you had the flu vaccine this season? __________

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I have received a copy of CJ Specialty Surgical Associates, LLC's Notice of Privacy Practices

________________________________ Name of Patient

________________________ Date

________________________________ Signature of Patient

________________________________ Signature of Guardian if patient under 18 y/o

________________________ Relationship to Patient

DISCLOSURES TO FAMILY, FRIENDS OR OTHERS:
Please indicate if we may provide your PHI to a family member, friend, or other person that is involved with your care.

Yes, I ______________________ authorize the disclosure of my medical records to:

____
Indicate name and relationship

____ NO I do not authorize the disclosure of my medical records.

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

_______________ *Date*

_______________ *Initials*

Reason: ____
____

10 Industrial Way East • Eatontown, NJ 07724 • Tel: 732.389.1331 • Fax: 732.542.8557

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Diplomate of the American Board of Surgery
Diplomate of the American Board of Colon & Rectal Surgery

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General and Advanced Laparoscopic Surgery
Diplomate of the American Board of Surgery

Steven J. Binenbaum, M.D. F.A.C.S., F.A.S.M.B.S.
Minimally Invasive
General and Bariatric Surgery

Gurdeep S. Matharoo, M.D., F.A.C.S.
Board Certified – American Board of Surgery
Advanced Laparoscopic, Robotic & Bariatric Surgery

Paul A. Kolarsick, M.D.
Diplomate of the American Board of Surgery
General Surgery
Colon and Rectal Surgery

MEDICAL RECORDS RELEASE FORM

DATE: ______________________

PATIENT: ____________________________________ **DOB:** __________

I, ____________________________________
(PRINT NAME OF PATIENT)

AUTHORIZE: ____________________________________
(PRINT NAME OF DOCTOR)

____
(ADDRESS)

____

________________ ________________
(TELEPHONE #) (FAX #)

TO RELEASE ALL MEDICAL RECORDS TO:

____

____

____

____

SIGNED: ______________________ **DATE:** __________

WITNESS: ______________________ **DATE:** __________

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APPOINTMENT CANCELLATION/NO SHOW POLICY
Effective May 2014

Dear Patient:

We will now be charging a fee for missed appointments. It is not our intent to inconvenience any of our patients, but in order to run our office as efficiently as possible we need to utilize cancelled appointments for other patients. Please read our cancellation policy carefully.

CANCELLATION/NO SHOW POLICY

If you are unable to keep your **Office Appointment**, a **24 hour notice** is required.

There will be a $75 charge for missed office appointments.

To cancel your OFFICE APPOINTMENT: Please call 732-389-1331 and follow the prompt.

If you are unable to keep your appointment for a **Surgical Procedure**, **two business days notice** is required. Cancellation secondary to medical necessity is not included.

There will be a $350 charge for a missed surgery.

To cancel your SURGERY: Please call 732-389-1331 and enter extension 3 for the Surgical Scheduler. If you are forwarded to their voicemail, please hit "0" and tell our receptionist that you need to cancel your procedure with a Scheduler.

THANK YOU FOR YOUR CONSIDERATION.

Patient Name: ______________________________ Date: _______ / _______ / _______

Patient Signature: ___________________________ Date: _______ / _______ / _______

PLEASE MAIL OR FAX TO 732-542-8587 PRIOR TO YOUR PROCEDURE. *Thank you.*