Please complete the information below as it is needed for our Electronic Medical Records. This information is requested by the state. We appreciate your cooperation in completing this form.

Name: ______________________ Date: ______________________

Pharmacy Name: ______________________

Pharmacy Address: ______________________

Pharmacy Phone: ______________________

Race:
____ Asian
____ Black
____ Hispanic
____ White

Language:
____ English
____ Spanish
____ Sign Language
____ Other

Ethnicity:
____ Latino
____ Not Latino

Patient Information Sheet
(Please Print)

Date: ________________

Patient Name: ______________________________ Date of Birth: ______________________
Last First M.

Street Address: ______________________________ City: ____________ State: _______

Zip Code: _____________ Home Phone (___) ____________ Cell Phone (___) ____________

Social Security #: _________________________________ Male _______ Female _______

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Referred By: ____________________________________

Employer: ______________________________________ Telephone (___) ______________________

Address: ____

Spouse's Name: _________________________________ Telephone (___) ______________________

Spouse's Employer: _____________________________ Address: _____________________________

** **INSURANCE INFORMATION** **

Is this a Workman's Compensation case? Yes_____ No_____ Claim #: _____________________
Adjuster's Name: ____ Telephone: (___) ______________

Primary Insurance Carrier: ____________________________ ID #: _____________________________
Address: ____ Group #: __________________________

IF POLICY OWNER IS DIFFERENT FROM PATIENT THE FOLLOWING INFO MUST BE PROVIDED
Policy Owner Name: _________________ S.S#:_________________ D.O.B: ___________
Policy Owner Employer: ____

Secondary Insurance: ____________________________ ID#:_____________________
Address: _____________________________________ Group #: __________________

IF POLICY OWNER IS DIFFERENT FROM PATIENT THE FOLLOWING INFO MUST BE PROVIDED
Policy Owner Name: _________________ S.S#:_________________ D.O.B: ___________
Policy Owner Employer: ____

Person to Notify in Case of Emergency: _________________________ Relationship: ________________

Address: ____ Telephone: (___)______________

The Following Documents are Required: (1) Referral(s) (2) Insurance Card(s) (3) Driver's License

Please sign and return to receptionist:
I, the undersigned, am insured and assign directly to Joseph B. Baratta, MD, all surgical and/or medical benefits, if any, otherwise payable to me. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the release of any information necessary to secure payment.

Date:____________________________ Signed: ______________________________________

General & Vascular Surgical Associates of North Jersey, P.A.
Joseph B Barata, M.D., F.A.C.S.

WELCOME TO OUR OFFICE

PLEASE READ CAREFULLY

I, agree to give the office at least 7 days prior to any elective cancellation of my scheduled surgery. There will be a charge to me of $100.00 for any cancellation not made within this time limit. If I cancel the day of the surgery without proper justification there will be a charge of $200.00.

Signature: ______________________________ Date:______________

We regret that this policy must be implemented, but the rising operating costs and decreased insurance reimbursement necessitate this action.

Thank you for your cooperation.

Joseph Baratta
General & Vascular Surgical Associates of North Jersey, P.A.
905 Allwood Road, Suite 204, Clifton, NJ 07012

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE
This form complies with the HIIPAA Privacy Rule

Patient Information
(Please Print)

Patient Name: ______________________________ Street Address: ___________________________________

City: ________________ State: ______ Zip Code: _____________ Date of Birth: _____________________

I hereby authorize: ____
Name of Physician's office/medical practice disclosing information

Please disclose the following protected health information to:

____

Street Address: P.O. Box _____________________________
City: _________ State: ____________ Zip Code: ______________

Please indicate the information or types of information to be disclosed:

____

Specify dates (or date ranges) if applicable: ____

This request is for the purpose of: ____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply or the information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months or on the following date:

____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted disease, tuberculosis or genetics.

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE ____________

____ _____________________________
Signature of Patient or Authorized representative Date

____ _____________________________
Description of Representative's Authority (witness signature required) Signature of Witness

CANCER FAMILY HISTORY QUESTIONNAIRE

Original

Personal Information

Patient Name: ______________________ **Date of Birth:** ______________ **Age:** __________

Gender (M/F):________ **Today's Date(MM/DD/YY):**____________ **Health Care Provider:**______________

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☒ Y ☐ N	*EXAMPLE: BREAST CANCER*	45	—	—	Aunt Cousin	45 61	Grandmother	53
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐ Y ☐ N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome* *(see cancer list below)*

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology*** before age 60
- ☐ Abnormal MSI/IHC tumor test result *(colon/rectal/endometrial/uterine)*
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

Lynch Syndrome* *(see cancer list below)*

- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

**Lynch syndrome cancer includes: *Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas*

***MSI High histology includes: *Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:______________________________ Date: ____________

Health Care Provider's Signature: ______________________ Date: ____________

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:__________

Patient History Intake Form

NAME: ______________________ DOB: __________ Today's Date: __________

Chief Complaint (in your own words): ______________________

History of Present Illness: Where is the problem? ______________________

(Check off or write in best response below)

Quality/Feeling ? __achy__ burning__dull__ stabbing __steady__ tight______________

Radiation of pain to where? (part of body or no other pain) ______________

Pain Severity?__mild__ moderate,__severe , How often?______________

Duration- How long has this occurred? (# hours, days, weeks) ______________

Timing? __morning__ constant__ intermittently__end of day, ______________

Context – When does this happen? (after eating, laying down, walking, with exertion, at rest?) ________

____

Things that make this worse? __ eating__ resting,__ exertion__ bending__bowel movement__ emotional stress__lying flat__ medication__prolonged sitting or standing__ smoking__ urination__ weather changes,

____

Things that make this better? __Analgesics__cool compress__ diuretics__ elevation,__exercise,__fluids__ food__heat__ hot showers__ ice__ inhalers__ medication__nitroglycerin__ rest __ pain medication

____

Associated symptoms__anxiety__ appetite increase/decrease__ belching,__black stools__ bloating__ chest pain __constipation__ diarrhea__ difficulty sleeping or__ swallowing,__dizziness__ dry cough__fainting__ fatigue__fever__ flatulence__ generalized body malaise__ headaches__ heartburn__ irritability__ joint pain __nausea__ numbness__ palpitation__ shortness of breath__ tingling__ weakness__ weight gain/loss)

Other: ______________________

PAST MEDICAL HISTORY: *(Check off or write in your personal history below* __A-fib,__AIDS or HIV__ Alcohol or Drug Abuse__ Anemia__ Iron Deficiency__ Anxiety/Depression__ Arthritis__ Asthma__ Bronchitis__ Coronary Artery Disease__ Cancer__ Cartoid Disease,__Congestive Heart Failure__Chronic Obstructive Pulmonary Disease,__Chronic Renal Failure/HDD__ Chronic Renal Insufficiency__ Cerebral Vascular Accident__TIA__ Diabetes type ____, __Diverticulitis__ Deep Vein Thrombosis__ Gastroesphageal Reflux Disease__ Hepatitis type ____, __Hernia__ Hypertension__ Hypercholesterolemia__ Hypertension__ Meningitis__ Peripheral Artery Disease__Peripheral Edema__ Peptic Ulcer Disease__ TB__ Thyroid Disorder, other: ______________

PAST SURGICAL HISTORY(Procedures and dates)______________________

____

____

GYN HISTORY: *(please enter dates)* LMP: __________ Menopause: __________ Last Pap: __________

Are you pregnant? Yes/No How many pregnancies have you had? ______ Live births? __________

What kind of contraception do you use? ______________________________

MEDICATIONS: *(please enter all medications you are taking, including dose please)*

____

____

____

ALLERGIES: *(please enter all allergies you have, or write "no drug allergies")*

____

____

Signature: ______________________________ Today's Date: ______________________________

General & Vascular Surgical Associates of North Jersey, PA

Joseph B. Baratta, MD, FACS
Diplomate of American Board of Surgery
Elizabeth Coll, APN, RVT
Board Certified Nurse Practitioner
Brendon DiDonna, MMS, PAC

905 Allwood Road, Suite 204
Clifton, NJ 07012
Tel: (973) 778-6676
Fax: (973) 778-2666

28 Jackson Avenue
Pompton Plains, NJ 07444

61 Beaver Brook Road, Suite 301
Lincoln Park, NJ 07035

ADVANCE DIRECTIVES: FOR ALL PATIENTS 18 YEARS OR OLDER:

Advance Directives is a federal and state mandated Self-Determination Act enacted in 1990. This allows you to provide specific instruction and direction regarding your own medical wishes if you become incapacitated. The patient-physicians relationship provides a direct opportunity for you to discuss these types of decisions.

Do you have a "Living Will" or Advance Directives?

Yes____ No____

Would you like to know more about a "Living Will"?

Yes___ No____

Information given to patient?

Yes___ No___

Patients Name:____

Patients Signature:____________________________________ Date:________________

General & Vascular Surgical Associates of North Jersey, P.A
Consent to Use and Disclosure of Protected Health Information

Use and disclosure of Your Protected Health Information
Your protected health information will be used by General & Vascular Surgical Associates to disclose to others for the purpose of treatment, obtaining payment, or supporting day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use of Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

General & Vascular Surgical Associates may or may not agree to restrict the use of disclosure of your protected health information.

If General & Vascular Associates agrees with your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Policy Practices
General & Vascular Surgical Associates reserves the right to modify the privacy practices outlined in this notice.

Signature
I have reviewed this consent form and give my permission to General & Vascular Surgical Associates to use and disclose my health information in accordance with it. I have also received a copy of their privacy practices

____

Signature Date

____

Signature of Patient Representative Relationship

YOUR INSURANCE COMPANY

In the past few years the number of different health insurance programs has increased at an amazing rate. Even with one company there may be several programs with varying benefits and requirements. There is no way we can possibly know, or keep up to date with each program's provisions. Some programs require a specific facility to be used for your X-Rays, ultrasounds, or blood tests. Some programs require authorization, while others do not. Some programs require PATIENTS to notify them of hospital admissions or of trips to the emergency room. Some programs require notification regarding hospitalizations.

IT IS YOUR RESPONSIBILITY TO KNOW:

Whether this office is participating with your insurance plan and program.
To advise this office of your program's requirements in advance, each and every time we provide you a service. We will do our best to comply with any reasonable requirements that your program may have.
***If you fail to pay any balance due on your account and it goes to our collection agency you will be responsible for the 25% collection fee in addition to the balance that you owe us*.**

RECORDS

You the patient are entitled to any and all records that pertain to your medical condition. For medical/legal reasons we never release the original records. Reports are only released to the patient or someone that the patient specifically designates. Copies of office assessments, and outside tests results are available. If you would like to view your records or obtain copies of your records, the office will comply with your request writing 30 days after a written release is received.

PATIENT PRIVACY

In order to protect your privacy and in accordance with Federal Law we do not leave confidential medical information on answering machines or with anyone other than the patient or the patient's legal guardian without prior authorization.

Please indicate below your preference:

___ We may leave detailed messages on this answering machine # __________________

___ We may confirm your appointments on your answering machine

___ Do not leave detailed messages on any answering machine

___ you may leave a detailed message with this/these

Person/People ______________________________ at this # ____________________

E-mail address: ____

Can we communicate with you through your E-mail?
Yes ___ No ___

____

Signature Print Name Date