KESPRA MEDICAL CENTER

22 Meridian Rd, Suite 10 Edison, NJ 08820

PATIENT REGISTRATION FORM

Patient Name: _____
(Last) (First) (Middle)

Birth Date: ____/____/____ **Social Security #:** ____/____/____

Age: _____ **Gender:** (circle) male - female

Race: _____ **Ethnicity:** _____

Language Preference: _____ **Marital Status:** _____

Home Address: _____
(Number) (Street) (Apt #) (City) (State) (Zip Code)

Work Address: _____
(Number) (Street) (Suite #) (City) (State) (Zip Code)

Home Phone No. (____) _____ **Cell Phone No.** (____) _____

Work Phone No. (____) _____ **Email:** _____

Emerg. Contact: _____ **Emerg. Phone No.** (____) _____

Preferred Pharm: _____ **Pharm. Phone No.** (____) _____

Primary Care Phys: _____ **Referring Phys:** _____

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Primary Insurance: _____
Subscriber Name: _____

Subscriber Birth Date: ____/____/____
Subscriber Social Security #: ____/____/____

Employer: _____ **Effective Date:** ____/____/____
(Mo) (Day) (Year)

ID #: _____ **Group/Policy#:** _____

Insurance Address: _____
(Number) (Street) (Suite #) (City) (State) (Zip Code)

Secondary Insurance: _____
Subscriber Name: _____

Subscriber Birth Date: ____/____/____
Subscriber Social Security #: ____/____/____

Employer: _____ **Effective Date:** ____/____/____
(Mo) (Day) (Year)

ID #: _____ **Group/Policy#:** _____

Insurance Address: _____
(Number) (Street) (Suite #) (City) (State) (Zip Code)

☐ INSURANCE ASSIGNMENT & RELEASE: I certify that I (or my dependents) have insurance coverage with the above listed companies and assign directly to Dr. P. Patel all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible for all financial charges whether or not paid by the insurance company. I authorize the use of my signature of all insurance submissions. Dr. P. Patel may use my health care information and may disclose such information to the above named insurance company (ies), and their agents for the purposes of obtaining payment for services rendered and determining insurance benefits, or the benefits payable for related services.

☐ MEDICARE/MEDIGAP AUTHORIZATION: I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits made either to me or on my behalf to Dr. P. Patel, for any services furnished to me by the provider. To the extent permitted by law, I authorize any holder of medical or other information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Representative_____

PRINT NAME_____DATE:_____/_____/_____

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HISTORY FORM

MEDICAL HISTORY:

Please Circle Medical Problems Listed Below
(Please Include The Duration or Date The Medical Problem Was Diagnosed)

Diabetes	COPD/Lung Disease	Cancer
High Blood Pressure	Leg Swelling/Edema	Lupus
Kidney Disease	Hepatitis B or C	Gout
Protein In Urine	Recurrent Sinusitis	Liver Disease
Blood In Urine	Polycystic Kidney Disease	Heart Attack
Kidney Stones	HIV/AIDS	Congestive Heart Failure
High Cholesterol	Urinary Tract Infection (s)	Enlarged Prostate

Please List Other Medical Problems Not Listed Above:

_____

_____

_____

_____

SURGICAL HISTORY:

Please Circle Procedures/Surgeries Listed Below
(Please Include The Date/Location The Procedure Was Performed)

Kidney Artery Stent	Gall Bladder Surgery	Kidney Biopsy
Bypass Surgery	Colon Surgery	Leg Bypass Surgery
Angioplasty	Carotid Surgery	Bladder Surgery
Coronary Stent	Eye – Laser Surgery	Cystoscopy
Heart Valve Surgery	Prostate Surgery	Urinary Stent Placement
Amputation(s)	Kidney Artery Stenting	Kidney Removal/Surgery

Please List Other Procedures/Surgeries Not Listed Above:

_____

_____

_____

_____

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Please List Your Medications Below		
MEDICATION NAME	DOSE (gm, mg, mcg, units)	TIMES PER DAY
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

PLEASE LIST ANY DRUG ALLERGIES:

_____

_____

FAMILY HISTORY:

Please Circle If Any Family History Of Medical Problems Listed				
RELATION	AGE	ALIVE or DECEASED	MEDICAL PROBLEMS	CAUSE OF DEATH
Father				
Mother				
Sibling(s)				
Children				

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Kespra Medical Center LLC** to use and/or disclose certain protected health information (PHI) which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations.

This authorization permits **Kespra Medical Center LLC** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

I understand that while this consent is voluntary, if I refuse to sign this consent, **Kespra Medical Center LLC,** can refuse to treat me. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Kespra Medical Center

22 Meridian Rd, Ste. 10

Edison, NJ 08820

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

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NAME:_____ **DATE:**_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Sleep Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name		Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender: Male ○ Female ○	Neck Size +2 Male ≥16.5 +2 Female≥15.0
Height	Feet / Inches		**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score TOTAL the values from all 8 questions, If 11 or less **Score = 0** If 12 or more **Score = 2**

Score

Frequency 0 - 1 times/week 1 - 2 times/week 3 - 4 times/week 5 - 7 times/week

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code / Phone Number	**Total all 6 boxes from above** If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	**Point Total**

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Fall Risk Assessment - STEADI (Stopping Elderly Accidents, Deaths & Injuries) Assessment

Please circle "Yes" or "No" for each statement below		
Yes (2)	**No (0)**	I have fallen in the past year.
Yes (2)	**No (0)**	I use or have been advised to use a cane or walker to get around safely.
Yes (1)	**No (0)**	Sometimes I feel unsteady when I am waliking.
Yes (1)	**No (0)**	I steady myself by holding onto furniture when walking at home.
Yes (1)	**No (0)**	I am worried about falling.
Yes (1)	**No (0)**	I need to push with my hands to stand up from a chair.
Yes (1)	**No (0)**	I have some trouble stepping up onto a curb.
Yes (1)	**No (0)**	I often have to rush to the toilet.
Yes (1)	**No (0)**	I have lost some feeling in my feet.
Yes (1)	**No (0)**	I take medicine that sometimes makes me feel light-headed or more tired than usual.
Yes (1)	**No (0)**	I take medicine to help me sleep or improve my mood.
Yes (1)	**No (0)**	I often feel sad or depressed
Total _____	Add up the number of points for each "yes" answer. **If total score is 4 points or more, then patient needs to be evaluated for gait, strength and balance problems using Timed Up and Go (TUG) Test.** http://www.cdc.gov/homeandrecreationalsafety/pdf/steadi/timed up and go test.pdf	

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Health Assessment for Man

Name: _____ Date: _____

E-Mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

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Health Assessment for Women

Name: _____ Date: _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		