Peter E Kagan, M.D.

222 Cedar Lane, Suite 111
Teaneck NJ, 07666
Tel: 201-227-6222

In order for us to see you for your appointment, the enclosed forms must be filled out completely before your visit.

You must bring the following with you:

- **Insurance Card**
- **Photo ID**
- **Defibrillator and Pacemaker Cards**
- **Complete list of medications**
- **Recent Test Results**

If you **DO NOT** have these items at the time of your visit, you will be asked to **RESCHEDULE** appointment for another day.

Thank You

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Last Name: _____________________ **First Name:** __________________________ **Middle Initial** ___________

Date of Birth: ____/____/____ **Gender:** □ **Male** □ **Female** **SS#** _________________________

Ethnicity: □ **Caucasian** □ **Hispanic / Latino** □ **African / Black** □ **Native American** □ **Asian** □ **Pacific lander**

Address: ____

City: ___________________ **State** ______ **Zip:** _______ **Cell Phone:** (___) ____________

Home Number: (___) _____________ **Work:** (_____) _____________ **Email:** _______________@__________

Employer: ______________________________________ **Occupation:** _________________________________

Primary Care Physician: __________________________ **Referring Physician:** __________________________

Pharmacy Name: _________________________________ **Pharmacy Number:** __________________________

Pharmacy Address: ____

Emergency Contact Information

Name: ______________________________ **Relationship:** _____________ **Phone:** (____) __________________

Primary Insurance: _____________________ **Policy #:** ____________________ **Group #:** _________________

Name of Policy Holder: ______________ **Date of Birth:** ____/___/____ **Effective Date:** ____/___/____

Secondary Insurance: ________________ **Policy #:** _______________ **Group #:** _________________

Name of Policy Holder: _____________ **Date of Birth:** ____/___/____ **Effective Date:** ____/____/___

□ ASSIGMENT OF BENEFITS: MY SIGNATURE BELOW INDICATES MY CONSENT FOR TREATMENT AND CONFIRMS MY UNDERSTANDING THAT ALL NON-COVERED ITEMS,CO-PAYMENTS AND DEDUCTIBLES ARE MY RESPONSIBILITY AND THE REALESE OF MY INFORMATION NECESSARY TO PROCESS MY CLAIM/S THAT WAS/WERE ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY INSURANCE COMPANY.

□ I AUTHORIZED ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO BE RELEASED TO THE SOCIAL SECURITY ADMINISTRATION AND THE CENTER FOR MEDICARE AND MEDICAID SERVICES OR ITS INTERMIDIARIES, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION NEEDED FOR THIS OR ANY RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGMENT.

□ I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PROVIDER OF SERVICE AND (OR) SUPPLIER FO ANY SERVICES FURNISHED TO ME BY THE PROVIDER OF SERVICE AND (OR) SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICARE INFORMATION ABOUT ME TO RELEASE TO:

MEDIGAP INSURANCE: ______________________________________ **HIC#:** _________________________

ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

Signature: ____ **Date:** _____/____/____

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GENERAL & VASCULAR SURGERY
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Last Name: ________________ **First Name:** ____________________ **DOB:** ___/___/___

Have you ever used tobacco? □ Yes □ No
How many packs per day? __________
How many years? __________
Quit Date: _____/____/_____

Alcoholic beverages per week? _______

Do you use any illicit drugs? □ Yes □ No

If yes, which one(s)?
____

Surgeries: (type and Date)
____
____
____
____
____
____
____
____
____
____

Medications: (Name, dosage, frequency)
Please include over the counter medications.
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Allergies: (drug and reaction)
____
____
____
____

Family History

	Age	List of all Medical Conditions	If not living, cause of death
Mother			
Father			
Brother(s)			
Sister(s)			

Last Name: ______________________First Name: _______________________DOB: ___/___/____

Reason for today's visit: ____

Check yes or no to indicate whether or not have had or now have the following conditions:

Condition			Condition		
Anemia	□ Yes	□ No	**Hypertension (*high blood pressure)***	□ Yes	□ No
Arthritis	□ Yes	□ No	**Hyperlipidemia (*high cholesterol)***	□ Yes	□ No
Asthma	□ Yes	□ No	**Obstructive Sleep Apnea**	□ Yes	□ No
Atrial Fibrillation	□ Yes	□ No	**Peptic Ulcer**	□ Yes	□ No
Blindness	□ Yes	□ No	**Seizures**	□ Yes	□ No
Blood transfusion	□ Yes	□ No	**Sickle Cell Disease**	□ Yes	□ No
COPD	□ Yes	□ No	**Stroke**	□ Yes	□ No
Diabetes	□ Yes	□ No	**Thyroid Problems**	□ Yes	□ No
Emphysema	□ Yes	□ No	**Cancer**	□ Yes	□ No
Heart Disease	□ Yes	□ No	**Type: ____________________________________**		
Heart Failure	□ Yes	□ No	**_______________________________________**		
Pacemaker/Defibrillator (*please Provide card)*	□ Yes	□ No			
Kidney Disease	□ Yes	□ No	**Dialysis** **Location: ___________________________________** **___________________________________**	□ Yes	□ No
Hemophilia	□ Yes	□ No	**Phone Number: ______________________________**		
Hepatitis Type: ________	□ Yes	□ No	**Days: M T W TH F SAT**		
HIV/AIDS	□ Yes	□ No	**Last Colonoscopy: ______________________________**		
Cardiac Stents	□ Yes	□ No	**Do you take blood thinners (Coumadin, Lovenox, Xeralto, Plavix, Aspirin, etc)**	□ Yes	□ No

Date Placed: __________
How Many? ___________

If yes, name/dose? ______________________

Signature: ____ Date: _______________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY ACTS (NPP)

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.**
- **Obtain payment from insurance and third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and discussed to carry out treatment, payments, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by those restrictions.

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how heath information about me may be used and disclosed by this office, and how I may obtain access to and control this information.

____ ________________
Signature of Patient or Personal Representative **Date**

____ ________________
Print Name of Patient or Personal Representative **Date**

OFFICE USE ONLY

I was not able to obtain the patient's acknowledgement of receipt of NOPP upon registration:
( ) The patient refused to sign despite good faith and efforts.
( ) The patient was unaccompanied and not alert/oriented.
( ) The patient was unaccompanied and needed emergency care.
( ) Other, (please explain): ____

Employee signature: ____________________________ **Employee Title: ______________________________**

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I hereby authorize ____________________________________ to furnish to ______________________
Information, access to, or photocopies of the medical records, with limitations as listed below

1. Nature of information to be released:

History/physical exam	**Discharge summary**	**Consultative reports**
Operative reports	**Pathology report(s)**	**X-Ray reports**
Laboratory reports	**Physical therapy notes**	**Progress notes**
Nurses notes	**Emergency Department records**	**Other:**

2. This authorization is confined to the following dates of treatment: ____________ to : _____________
(mm/dd/yyyy) (mm/dd/yyyy)

3. Purpose of release: ____
Sensitive information: I understand that the information released from my medical record may include information relating to sexually transmitted diseases, HIV/AIDS related information (including the fact that an HIV test was ordered, preformed or reported, regardless of whether results of such test were positive or negative). It may also include information about behavioral or mental health services, drug and alcohol information, genetic information and tuberculosis information. I approve of release of such information by initiating:
HIV/AIDS ________ Drug or Alcohol _________ Mental Health ___________ Genetics ____________

I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the rule.
I further direct that only information prior to the date below be honored, and that a photocopy of this authorization be granted the same authority as the original.
I further hereby release Holy Name Medical Center and you personally from all legal responsibility and/or liability that may arise from the release of such records as specified above, and I hereby waive all rights I have to preserve their confidentiality.
I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year's time. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

Signature of Patient: **____** ***Date:*** **_____________________**
If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signature:

Signature of Patient's Representative: **____** ***Date:*** **_____________________**

Description of Authority ____
(*Please note, a copy of the legal documents must be provided in order to prove authority if not signed by the patient.)*

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To Our Patients:

As you are aware, there are very strict government mandated rules concerning patient health information, confidentiality and release of information. In our continuing effort to improve patient care and communication, our practice offers you additional ways to receive information, with your signed authorization, concerning your care and treatment.

If there are any other persons (family members/friends/health care professionals) with whom we may discuss or to whom we may release information please list them here:

Name	Phone Number/Relationship
1. ___________________________________	___________________________________
2.____________________________________	___________________________________
3. ___________________________________	___________________________________
4. ___________________________________	___________________________________
5. ___________________________________	___________________________________
6. ___________________________________	___________________________________

I understand that I may revoke or change this authorization at any time in writing.

Patient Name (Print) ____

Signature ____ Date ___________