CONFIDENTIAL

☐ New Patient
☐ Existing Patient

Existing Patients: only enter information that has changed since your last visit

☐ 19 CLYDE ROAD STE 101
SOMERSET, NJ 08873

GREGORY RIHACEK

REGISTRATION INFORMATION

PLEASE PRINT

DATE_____/____/_____ HOME PHONE: (___) ____ - _____

EMAIL ADDRESS _____ CELL PHONE: (___) ____ - _____

PATIENT: _____ , _____ _____
LAST FIRST MI

STREET ADDRESS _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY: ____ - ____ - ____ SEX: ☐ M ☐ F BIRTH-DATE: ____/____/____ ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

Patient Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Spouse/Responsible party Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Purpose of Visit: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ RELATIONSHIP TO PATIENT: _____ DOB: _____

SOCIAL SECURITY # : ____ - ____ - ____ SPOUSE'S SS # : ____ - ____ - ____

DO YOU HAVE MEDICAL INSURANCE? ☐ No ☐ Yes If Yes:

NAME OF PRIMARY INSURANCE COMPANY: _____

ID # : _____ Group # : _____ Subscriber Name : _____

Name of *Secondary* Insurance Company (if any): _____

ID # : _____ Group # : _____ Subscriber Name : _____

In case of emergency, who should be notified? _____ Phone: _____

Name of your Pharmacy: _____ Phone: _____

Who may we thank for referring you? _____ Phone: _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(NAME OF INSURED) (Name of Insurance Company)

to pay and hereby assign directly to _____ all benefits, if any, otherwise payable to
(Provider's Name)

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____
(Provider's Name)

will be credited to my account, in accordance with the above said assignment.

_____ _____
(AUTHORIZED SIGNATURE OF SUBSCRIBER) (DATE)

SEE REVERSE SIDE

GREGORY S. RIHACEK, M.D.
ARTHRITIS CARE MEDICAL CENTER

19 Clyde Rd., Suite 101, Somerset, NJ 08873 (732) 568-0023 Fax (732) 568-0159

IT IS MANDATORY THAT THE FOLLOWING INFORMATION ON THIS PAGE BE FILLED IN, INITIALED AND SIGNED.

Referral Information:
Primary or Referring Dr.: _____
Address: _____
Telephone/Fax #'s: _____
Pharmacy:
Pharmacy Name: _____
Address: _____
Telephone/Fax #'s: _____
Person to Notify in Case of Emergency:
Name/Relationship: _____
Address: _____
Telephone: _____

CONSENT FOR MEDICAL TREATMENT: I hereby voluntarily consent to such medical care encompassing diagnostic and theraputic procedures, medical photography, and medical treatment as may be ordered by my physician, his designees, as is necessary in his/her treatment. Please initial_____.

AUTHORIZATION TO RELEASE INFORMATION: I hereby agree that my Physisian and staff may give out written or verbal information concerning my hospital records, to any insurance carrier or agent that is authorized to have access to, and to make copies of my medical records. Please initial_____.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I Hereby assign all benefits due me by my insurance carrier to be paid directly to Gregory S. Rihacek, M.D. Please initial_____.

NON-CANCELED APPOINTMENTS: I understand that when I make an appointment and do not call within 24 hours to cancel, I may be charged $30.00. Please initial_____.

FINANCIAL AGREEMENT: I hereby agree to pay all statements not covered by insurance for services rendered by the physician and medical staff at the end of the medical service. Any balance not paid within 30 days of recepeipt of the statement will be considered in default unless finacial arrangements have been made with the billing department. Please initial_____.

The undersigned certifies that he/she has read the forgoing, received a copy if requested, and is the patient, or duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____
(Signature) (Date)

SIGNATURE ON FILE: I request that payment of the authorized Medicare/Commercial Insurance benefits be made either to me or on my behalf to Gregory S. Rihacek, M.D. for services furnished to me by the provider. I authorize any holder of medical information about me to release to Health Care Administration and its agents any information needed to determine these benefits of the benefits payable for related services.

_____
(Signature) (Date)

WE CHARGE $85 NEW PATIENT NO SHOWS AND $30 AFTER THAT.

HEALTH HISTORY

PLEASE DO NOT MAIL BACK
PLEASE COME PREPARED WITH YOUR INSURANCE CARDS/ COPAY/REFERRAL, WE DO NOT ACCEPT CREDIT CARDS.

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name _____ Birthdate _____ Patient # _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
(What other associated problems have you been having?)

Modifying factors _____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History
Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes			
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes			
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medications: (Include nonprescription) _____
_____
_____

Patient social history:

Marital status	Single:_____	Married: _____	Separated: _____	Divorced:_____	Widowed:_____
Use of alcohol:	Never:_____	Rarely:_____	Moderate:_____	Daily:_____	
Use of tobacco:	Never:_____	Previously, but	quit:_____	Current packs / day: _____	
Use of drugs:	Never:_____	Type/Frequency:	_____		
Excessive exposure at home or work to:	Fumes:_____	Dust:_____	Solvents:_____	Air-borne Particles:_____	Noise:_____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**
- Good general health lately ..... No Yes
- Recent weight change ..... No Yes
- Fever ..... No Yes
- Fatigue ..... No Yes
- Headaches ..... No Yes

☐ **Eyes**
- Eye disease or injury ..... No Yes
- Wear glasses/contact lenses .... No Yes
- Blurred or double vision ..... No Yes

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing ..... No Yes
- Earaches or drainage ..... No Yes
- Chronic sinus problem or rhinitis . No Yes
- Nose bleeds ..... No Yes
- Mouth sores ..... No Yes
- Bleeding gums ..... No Yes
- Bad breath or bad taste ..... No Yes
- Sore throat or voice change .... No Yes
- Swollen glands in neck ..... No Yes

☐ **Cardiovascular**
- Heart trouble ..... No Yes
- Chest pain or angina pectoris ... No Yes
- Palpitation ..... No Yes
- Shortness of breath w/walking or lying flat ..... No Yes
- Swelling of feet, ankles or hands. No Yes

☐ **Respiratory**
- Chronic or frequent coughs .... No Yes
- Spitting up blood ..... No Yes
- Shortness of breath ..... No Yes
- Wheezing ..... No Yes

☐ **Gastrointestinal**
- Loss of appetite ..... No Yes
- Change in bowel movements ... No Yes
- Nausea or vomiting ..... No Yes
- Frequent diarrhea ..... No Yes
- *Painful* bowel movements or constipation ..... No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain ..... No Yes

☐ **Genitourinary**
- Frequent urination ..... No Yes
- Burning or painful urination ... No Yes
- Blood in urine ..... No Yes
- Change in force of strain when urinating ..... No Yes
- Incontinence or dribbling ..... No Yes
- Kidney stones ..... No Yes
- Sexual difficulty ..... No Yes
- Male - testicle pain ..... No Yes
- Female - pain with periods .... No Yes
- Female - irregular periods ..... No Yes
- Female - vaginal discharge .... No Yes
- Female - # of pregnancies ... _____
- Female - # of miscarriages ... _____
- Female - date of last pap smear _____

☐ **Musculoskeletal**
- Joint pain ..... No Yes
- Joint stiffness or swelling ..... No Yes
- Weakness of muscles or joints .. No Yes
- Muscle pain or cramps ..... No Yes
- Back pain ..... No Yes
- Cold extremities ..... No Yes
- Difficulty in walking ..... No Yes

☐ **Integumentary (skin, breast)**
- Rash or itching ..... No Yes
- Change in skin color ..... No Yes
- Change in hair or nails ..... No Yes
- Varicose veins ..... No Yes
- Breast pain ..... No Yes
- Breast lump ..... No Yes
- Breast discharge ..... No Yes

☐ **Neurological**
- Frequent or recurring headaches No Yes
- Light headed or dizzy ..... No Yes
- Convulsions or seizures ..... No Yes
- Numbness or tingling sensations No Yes
- Tremors ..... No Yes
- Paralysis ..... No Yes
- Head injury ..... No Yes

☐ **Psychiatric**
- Memory loss or confusion ..... No Yes
- Nervousness ..... No Yes
- Depression ..... No Yes
- Insomnia ..... No Yes

☐ **Endocrine**
- Glandular or hormone problem . No Yes
- Excessive thirst or urination .... No Yes
- Heat or cold intolerance ..... No Yes
- Skin becoming dryer ..... No Yes
- Change in hat or glove size ..... No Yes

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts ..... No Yes
- Bleeding or bruising tendency .. No Yes
- Anemia ..... No Yes
- Phlebitis ..... No Yes
- Past transfusion ..... No Yes
- Enlarged glands ..... No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics .. No Yes
- Morphine, Demerol, or other narcotics ..... No Yes
- Novocain or other anesthetics . No Yes
- Aspirin or other pain remedies No Yes
- Tetanus antitoxin or other serums ..... No Yes
- Iodine, Merthiolate or other antiseptic ..... No Yes
- Other drugs/medications: _____

_____

Known food allergies: _____

_____

Environmental allergies: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibilty to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

Patient Consent to Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, Gregory S. Rihacek, MD office originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can testify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that GREGORY S. RIHACEK, MD.' s office is not required to agree to the restrictions requested. I understanc that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereo I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand the GREGORY S. RIHACEK, MD.'s office reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should GREGORY S. RIHACEK, MD.'s office change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____ _____
Patient's Signature Date

Who else do you give authorization to receive your medical information?
Name: _____ **D.O.B:** _____
Relationship: _____
Address: _____
Tel: _____

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.