IMMC Health
Internal & Metabolic Medical Center

Patient Demographics

First Name | Last Name | Gender

Home Address | City/Town | State | Zip

Home Phone | Cell Phone | Work Phone | Email Address

Date of Birth | Social Security Number | Marital Status | Spouses' Name

Emergency Contact | Emergency Contact Phone Number | Relationship

Reason For Visit | Referring Physician | Primary Care Physician *(if seeing us as a specialist)*

Pharmacy Name | Pharmacy Address

Primary Insurance Carrier | Policy Number | Effective Date

Secondary Insurance Carrier *(if applicable)* | Policy Number | Effective Date

Patient Medical History

List any **Medical Conditions** you have been treated for.

List any **Surgeries or Procedures** you have had.

Procedure | Date | Procedure | Date

List any **Medications and Supplements** you are ***currently taking***. Please include **dosage** and **frequency**.

Do you have any known **food** or **drug** allergies? ○ No ○ Yes
If yes, please list:

Family Medical History

List any **Medical Conditions** present in your family. Include parents, siblings, maternal and paternal grandparents.

Medical Condition	Family Member	Medical Condition	Family Member

Social History

Tobacco Use: ○ Current ○ Former ○ Never

*If **Current** or **Former**:* Number per day: Number of years:

Alcohol Use: ○ Current ○ Former ○ Never

*If **Current**:* Have you ever felt you should cut down on your drinking? ○ Yes ○ No

Have people annoyed you by criticizing your drinking? ○ Yes ○ No

Taken a drink first thing in the morning to steady nerves or get rid of a hangover? ○ Yes ○ No

Have you ever felt bad or guilty about your drinking? ○ Yes ○ No

Recreational Drug Use: ○ Current ○ Former ○ Never

How many days per week do you exercise? Duration: *hours*

How many caffeinated drinks do you consume on a daily basis?

Sexually Active? ○ No ○ Yes

Social History *continued*

Employment Status: ○ Full Time ○ Part Time ○ Retired ○ Student ○ Unemployed

*If **Employed**:* Activity Level: ○ Desk/Office ○ Occasional physical work ○ Moderate physical work

Employer's Name:

Patient Health Questionnaire

How often have you been bothered by the below symptoms during the last two week?

Feeling down, depressed, hopeless	○ Not at all	○ Several days	○ More than half the days	○ Never
Little interest or pleasure in activities	○ Not at all	○ Several days	○ More than half the days	○ Never
Trouble falling asleep or staying asleep	○ Not at all	○ Several days	○ More than half the days	○ Never
Feeling tired or little energy	○ Not at all	○ Several days	○ More than half the days	○ Never
Poor appetite or overeating	○ Not at all	○ Several days	○ More than half the days	○ Never
Feeling bad about yourself	○ Not at all	○ Several days	○ More than half the days	○ Never
Trouble concentrating	○ Not at all	○ Several days	○ More than half the days	○ Never
Moving or speaking slowly	○ Not at all	○ Several days	○ More than half the days	○ Never
Thoughts better off dead or hurting self	○ Not at all	○ Several days	○ More than half the days	○ Never

Patient Release

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agents (including Medicare), for purpose of filling and payment of medical claims. I understand Dr. Elion Krok does not participate with all insurance companies. In the event that payment is not submitted directly to Dr. Elion Krok, I understand that it is my responsibility to submit any payment I receive for services rendered by Dr. Krok, directly to his office.

Patient Signature: _____ **Date:** _____

External Rx History Consent

I authorize IMMC Health to view my external prescription history via the electronic health record system, Cerner PowerChart. I understand that prescription history from multiple other medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff here, and it may include prescriptions from previous years.

Patient Signature: _____ **Date:** _____

New Jersey Immunization Information System (NJIIS)

What is the NJIIS?

A free, confidential, population-based online system that collects and consolidates vaccination data for New Jersey's children and adults. The NJIIS is the official Immunization Registry per the Statewide Immunization Registry Act - NJAC 8:57, subchapter 3, pursuant to N.J.S.A. 26:4-131 et seq. (P.L. 2004, c. 138).

What is the purpose of NJIIS?

NJIIS provides current recommended immunization schedules for infants, adolescents and adults. It consolidates immunization information from all providers into one record to provide an accurate immunization assessment and eliminates the use of manual vaccine administration logs.

NJIIS assists state and federal agencies with population assessments in the event of a preventable disease outbreak and helps communities assess their immunization coverage and identify pockets of need.

Who can enroll as an authorized user of NJIIS?

Any health care provider, child care center, school, college or university, health plan, billing and practice management vendor, state or local public health and social service programs, and agencies or designated agents thereof may participate in NJIIS.

Consent to Participate

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history. I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted by website (www.njiis.nj.gov) or telephone number (609-826-4860). There is no cost to participate in this program.

☐ I would like to participate in this program.
☐ No, I do not want to participate in this program.

Patient Signature: _____ **Date:** _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published, and becomes effective on/or before **April 14, 2003.**
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

By signing this document you are acknowledging that you have received this Notice of our Privacy Practices.

Patient Signature: _____ **Date:** _____