AtlantiCare
Physician Group

Your health and well-being are important to us and are our first priority. The following policies are currently in effect:

- Please bring all medication bottles (prescription and over-the-counter supplements) to each and every visit. This will help to improve safety and accuracy.
- All prescriptions for controlled medications (i.e. sleep aids, anxiety medication, pain medication, etc.) are issued for a period of 30-days at a time, there are no additional refills. For all other prescriptions, please allow 24 to 48 hours when requesting refills.
- Patients must call to cancel appointments at least 24 hours prior to the appointment time. If you fail to contact us, you will be considered a no-show. Three consecutive no-shows may result in discharge from the practice.
- Please carefully read the demographic and medications forms given to you at every visit. This is your chance to update all necessary information such as phone number, address, insurance, medication, etc. Bring driver's license, insurance card(s) and co-payment (if applicable) to each and every visit.

Thank you for choosing AtlantiCare for all your health care.

PRIMARY CARE
AtlantiCare
Physician Group

PATIENT INFORMATION:

Reason for visit (if an injury, how did it occur): ______________________________

Please give date of accident or symptoms: _____/_____/_____

If injury, is it related to: Worker's Comp? Yes/No Motor Vehicle? Yes/No

First Name: ________________ Middle Initial: _____ Last Name: ____________________

Social Security Number: _____/_____/_____ Date of Birth: _____/_____/_____ Age: ________

Sex: Male/Female Marital Status: (circle one) Single/Married/Divorced/Widowed/Partner

Address: ____

City: ______________________ State: __________________ Zip: ________

Home Phone: ( ) _____-_______ Cell Phone: ( ) _____-_______ Work: ( ) _____-_______

Is it okay to leave a message: at home? Yes/No cell phone? Yes/No

If okay to leave a message, may we leave a ◻ brief message ◻ extended message?

E-mail address: ____________________ Preferred method of contact: Home/Cell/E-mail?

Primary Language: ________________ Country of Origin: ________________________

Translator services required? Yes/No

Ethnicity: ______________________ Race: __________________

Are you visually impaired? Yes/No Are you hearing impaired? Yes/No

Employment Status: (circle one) Full-time/Part-time/Self-employed/Retired/Military

Patient's Occupation? ______________

Employer: ______________________ Address: _________________________________

City: _________________________ State: ______________ Zip: _____________

If student, indicate school: __________________________________ Full-time/Part-time

Do you have an Advanced Directive? Yes/No

If no, would you like more information about an Advanced Directive? Yes/No

PHARMACY INFORMATION:

Retail Pharmacy Name: ______________________________

Phone ( ) ____________ Fax ( ) ____________ Location: ____________

ID# ____________

Mail Order Pharmacy Name: ______________________________

Phone ( ) ____________ Fax ( ) ____________ Location: ____________

ID# ____________

PREFERRED LAB COMPANY:

□ ACL (AtlantiCare)
□Labcorp
□Quest

PRIMARY CARE PHYSICIAN: ______________________________

REFERRING PHYSICIAN: ______________________________

EMERGENCY CONTACT INFORMATION (if patient is an adult) or Parent/Guardian information (if patient is a minor):

First Name: ____________ Middle Initial: ____ Last Name: ____________

Relationship to Patient: ____________ Home Phone ( ) ____________

Work Phone ( ) ____________ Cell Phone ( ) ____________

INSURANCE INFORMATION:

Name of PRIMARY insurance ______________________________

If Medicare: Is the patient a veteran? Y/N Are you currently employed? Y/N

Do you have a Federal Black Lung Card? Y/N Is your spouse/partner currently employed? Y/N

Policy/Subscriber# ____________ Group # ____________

How is the subscriber related to you? Self/Spouse/Child/Guardian

AtlantiCare
Physician Group
CONSENT FORM

PATIENT NAME:

Consent for treatment: Knowing that I (or the patient indicated on the top of this form) am suffering from a condition requiring treatment, I voluntarily consent to such care. I consent to routine diagnostic procedures, x-rays, and to medical treatment by physicians in AtlantiCare Physician Group and other health care providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my care, treatment or examination at AtlantiCare Physician Group. Patients at AtlantiCare Physician Group will be treated regardless of race, color, age, national origin, disability or religion.

Signature of patient or patient representative: X ______________________ Date from:________ to: 12/31/2015

(Representative signature required if patient is minor or unable to consent): ______________________

Representative's relationship to patient: ______________________ Witness: ______________________

Patient is unable to consent because: ______________________

Acknowledgement of Privacy Practice: I understand and have been provided with AtlantiCare's *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. AtlantiCare reserves the right to make changes to their Privacy Notice. Revised copies are available at all patient registration areas. By signing this form, I acknowledge that I have been afforded the opportunity to consider AtlantiCare's Notice of Privacy Practices prior to signing of this consent and making of healthcare decisions.

Signature of patient or patient representative: X ______________________ Date from:________ to: 12/31/2015

General Terms and Conditions:

1. I understand that as a part of my healthcare, AtlantiCare Physician Group originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care. This information is used as described in the Notice of Privacy Practices and to: plan my care and treatment, communicate with professionals involved in my care, apply my diagnostic and procedural information to my bill, verify third party payers the services provided, and routine operations such as audits reporting requirements, utilization review, and quality assessment activities.
2. I am aware and have been advised that I (or the patient) am suffering from a condition requiring treatment and I am presenting myself for treatment and I voluntarily consent to such care. I consent to diagnostic procedures and medical treatment by physicians at AtlantiCare Physician Group's medical staff and other affiliates and health care professionals who may be called upon to consult or assist in my care as is necessary in their professional judgment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my care, treatment or examination at AtlantiCare Physician Group.
3. AtlantiCare Physician Group maintains patient medical records in paper, microfilm and /or electronic media, including photo identification, which may be accessible to any physician or health care provider participating in my current or future care. I understand that these records will contain information about my diagnosis and treatment and may or may not contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Medical records are disclosed according to applicable New Jersey State Laws, Federal laws 42 & 45 C.F.R. and the provisions of this consent.
4. I herby assign to AtlantiCare Physician Group physicians participating in my care and other licensed providers any and all rights and benefits to which I may be entitled arising out of any health care or liability insurance. I hold AtlantiCare Physician Group harmless for any reduction in healthcare benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: notification, pre-certification, prior or retrospective authorization , or utilization review of the medical services I receive. I agree that I am financially responsible for deductibles, coinsurance and uncovered services that are not covered by my insurance policy.
5. I agree to pay AtlantiCare Physician Group the full and final amount of any and all bills rendered for me (or the named patient) which are not covered by insurance. I authorize AtlantiCare Physician Group to utilize the appeals process with my insurance carrier in my behalf for any denied service.
6. I certify that the information given by me in applying for payment under titles XVIII and XVIX of the Social Security Act is correct. As acceptable, I certify that I have received the Important Message from Medicare.

By signing this consent, I am indicating that I understand the contents of this document and agree to its provisions including the disclosure of information in accordance with AtlantiCare's Notice of Privacy Practices. I am signing this consent voluntarily.

Signature of patient or patient representative: X ______________________ Date from:__________ to :12/31/2015

Representative's relationship to patient ______________________ Witness: ______________________

Patient is unable to consent because: ______________________

AtlantiCare
Physician Group

Today's Date ____/____/______

Patient's Name: ______________________________ DOB: ________________ SEX __________

MEDICAL HISTORY: (please check all that apply)

High Blood Pressure	Drug Abuse
High Cholesterol	Alcohol Abuse
Diabetes	Ulcers
Cancer	Hepatitis
Tuberculosis	HIV
Urinary Tract	Thyroid
Infections	Asthma
Anemia	COPD
Kidney Stones	Stroke
Kidney Disease	Angina
Gallbladder Disease	Lyme's Disease
Heart Disease	Arthritis
Depression	Other (please describe)

Do you have any Allergies to Medication, food or other: Y / N

Surgical History: (please list type of surgery, if any, and date)

Family History: (please check all that apply)

Blood Pressure	Stroke
Diabetes	Heart Attack
Cancer	Kidney Disease
Mental illness	Depression
Other (please describe)	Drug or Alcohol use

Social History

Alcohol:	Y / N	If yes, how many drinks are consumed, per week? __________
Cigarettes:	Y / N	If yes, how many packs per day? __________
Drug/Substance use:	Y / N	

Immunizations

Flu Vaccine ____________ TDAP ____________ Pneumonia Vaccine ______________

Other treating providers: (please list the name and specialty of any other provider currently treating you)

Name: ________________________ Specialty: ______________________

AtlantiCare
Physician Group

Today's Date: ______/______/______

Patient Name: ________________________________ DOB: _____/_____/_______

Please list all medications including vitamins and over the counter supplements and medications

Medication	MG/ Strength	Dose/ How Often

***NOTE:** It is always best to bring in your all medication, supplements and vitamins to all your medical visits.

Consent to discuss Care & Treatment

Patients Name: ______________________________ Birthdate: _____/_____/______

Practice Name______________________________ Primary Provider ________________

I permit the following information to be discussed with the following family member, friend or others person or persons listed below.

I understand that if I want any of the persons listed below to receive a copy of my records; I must complete and sign a separate authorization form.

In an emergency or if I am admitted to the hospital and unable to make my wishes known, I understand that my provider and hospital staff may rely on the above permissions to determine with whom they may discuss my care.

I can change the permissions stated below at any time by notifying my provider or AtlantiCare's Privacy office.

- ☐ Appointments only
- ☐ Results/ Plan of care ____
- ☐ My bill   Name   Relationship   Phone

- ☐ Appointments only
- ☐ Results/ Plan of care ____
- ☐ My bill   Name   Relationship   Phone

- ☐ Appointments only
- ☐ Results/ Plan of care ____
- ☐ My bill   Name   Relationship   Phone

Patient signature____ Date__________________________

Print name____

Signature of lawful personal representative* ______________________________ Phone______________

Print name____

*Required only if the patient is a minor or unable to represent self.