New Patient Demographics

Full Name: ____ Date of Birth: ____________ Gender: ____________

Address: ______________________________________City: _________________State________Zip____________

Home Phone: ___________________ Cell Phone: _______________________ Marital Status: __________________

Spouse/Next of Kin Name: _______________________________ Number: __________________________________

Emergency Contact: ____________________________________ Number: __________________________________

Employer Name: _______________________________________ Number: __________________________________

Primary Insurance: _________________________ Group No: _____________ Member ID: ___________________

Guarantor's Name: ___________________________________ Guarantor's DOB: ____________________________

Insurance Address: ____

Secondary Insurance: _______________________ Group No: _____________ Member ID: ___________________

Guarantor's Name: ___________________________________ Guarantor's DOB: ____________________________

Insurance Address: ____

Primary Care Physician: _________________________________ Phone No: _________________________________

Primary Care Physician Address: ____

Referring Physician (*if any*): _______________________________ Phone No: _______________________________

Referring Physician Address: ____

Preferred Pharmacy: ____________________________________ Phone No: _______________________________

Who can we thank for your visit: ____

2 Sears Drive. Suite 101
Paramus, NJ 07652
(201) 261-1772

Patient Medical History

Signature:

____ Date: _____________________

Patient Name: ____ Date: ___________________________

Medical History (*place X where applicable*)

____ High blood pressure ____High cholesterol ____Coronary Artery Disease____ Deep Vein Thrombosis ____ Stroke

____ Renal Insufficiency Syndrome ____ Diabetes ____ Thrombophlebitis ____ Aneurysm ____ Eczema ____ Thyroid Disorder

____ Peripheral ☐ Vascular Disease ____ Peripheral Neuropathy Other *(please explain)*:________________________________

Family History: No knowledge of family history

Clotting Disorder Y or N Family member? _________ Bleeding Disorder Y or N Family member? ________

Coronary Artery ☐ Disease Y or N Family member? _________ Stroke Y or N Family member? _________

Aneurysm Y or N Family member? _________ Varicose Veins Y or N Family member? _________

Other family history: ____

Surgical History: No past surgical history **Year**

Past Varicose Vein Surgery w/ Stripping YES or NO ____

____

____

____

Social History:

Tobacco Use Y or N _______ packs per day Alcohol Use Y or N _______ frequency

Sun Exposure Y or N _______ how often? ☐ Are you currently pregnant/breastfeeding? Y or N

Living Situation: *(please circle one)* With Spouse With Family Alone Nursing Home

Current Medications: *(please include dosage and frequency)* Not currently on any medication

☐

Blood thinners YES or NO Birth Control YES or NO ____

Accutane_ YES or NO____________ Retin A _______YES or NO______________________________

____

____

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Allergies: No known allergies

Release of Information

____

____

____

Patient Name: ____ Date: ___________________________

Please list the family members or other persons, if any, whom **Chuback Medical Group** may inform about your general medical condition and your diagnosis. *(You may write "no one," You may revoke this permission in writing at any time.)*

____

____

Please print the e-mail where you would like to be contacted about your appointments, ultrasound results, other healthcare information or special offers.

I am fully aware that e-mail is not a secure means of communication

____

Please print the telephone number where you want to receive calls about your appointments, ultrasound results, or other healthcare information, if other than your home phone number.

I am fully aware that a cell phone is not a secure and private line

____

Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

YES ________ NO ________

Do you currently have a Power of Attorney (POA) or Living Will?

YES ________ NO ________

Patient/Guardian/POA Signature: ____

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Date: ______________________

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Acknowledgement of Receipt of Notice of Privacy Practices

The Chuback Medical Group reserves the right to modify the privacy practices outlined in the notice.
I have received a copy of the Notice of Privacy of Privacy Practices for Chuback Medical Group

___________________________________	___________________________________
Patient Name	Patient Signature
___________________________________	___________________________________
Signature of Patient Representative*	Relationship to Patient

____
Date

*Required if the patient is a minor or an adult who is unable to sign this form

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Financial Policy

Thank you for choosing **Chuback Medical Group** for your medical and surgical needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your overall treatment plan. The following is a statement of our *Financial Policy*, which we require every patient to read and sign prior to any treatment.

I_______________________________, assign Chuback Medical Group all of my rights and benefits under any insurance contract for payment for services rendered to me by Chuback Medical Group.

Please initial each statement

_____I authorize Chuback Medical Group to file insurance claims on my behalf for service rendered.

_____I request that payment from my insurance company be made directly to
Dr. John A. Chuback.

_____I direct that any and all payments go directly to Chuback Medical Group.

_____I agree that in the event I receive any checks, or other payments subject to this Agreement, such payments will be held, endorsed to the Chuback Medical Group and forwarded to their office.

_____I authorize Chuback Medical Group to release in writing or verbally, any medical information regarding treatment which may be needed for my care, or for processing medical insurance claims. This includes information directly related to obtaining precertification or predetermination of covered benefits by my insurance company.

_____I authorize Chuback Medical Group to appeal any claims, precertification, and/or predetermination cases on my behalf.

_____I certify that the insurance information that I have provided is correct.

_____I agree that if I do not have health insurance, payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns regarding the above information. I have read the Financial Policy and I understand and agree to the Financial Policy.

Patient Name: ____________________________ ___Signature: ______________________________Date: __________

Please share with us . . .

Here at Chubback Medical Group, we are passionate about helping you improve your total health and well-being. Tell us about any other areas of concern that you may have. Together we can achieve a new, incredible you.

Check any concerns that apply to you:

- □ Facial Lines and Wrinkles
- □ Facial Volume Loss
- □ Thin Lips
- □ Facial Rejuvenation
- □ Hand Rejuvenation
- □ Excessive Sweating
- □ Sun/Age Spots
- □ Suspicious Lesions
- □ Cellulite
- □ Unsightly Varicose Veins
- □ Unsightly Spider Veins
- □ Unwanted Hair
- □ Unwanted Fat
- □ Body Contouring
- □ Breast Augmentation/Reduction
- □ Buttock Augmentation/Reduction
- □ Tummy Tuck/Liposuction
- □ Skin Tightening
- □ Weight Loss
- □ Eyelash Enhancement
- □ Drooping Eyelids
- □ Hair Loss/Thinning Hair
- □ Other: ____

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Authorization for Release of Medical Information

Patient Information:

Name: ____

SS#: ______________________________ DOB: _________________

I, ______________________ hereby authorize The Chuback Medical Group to:

☐ Release my medical information
☐ Obtain my medical information

I authorize the following person(s) and/or organization to release/obtain the information:

Name of Person/Organization: ____________________________________

Address: ____

Phone Number: (_____) ________-__________

Reason for release of information: ____

Information to be released:

a.	O Office visits	O History & Physical
b.	O Emergency Department Reports	O All clinical reports -including but not limited to:
c.	O Discharge Summary	Cardiac, Laboratory, Radiology
d.	O Operative Reports	O Other ________

I understand that my treatment information released under this consent may be re-disclosed by the recipient of the information and may no longer be protected by Federal law.

This authorization will expire in one year from date signed, or sooner by choice, in which case this authorization will expire on _________________. I understand that I may revoke this authorization at any time by notifying, in writing, the Chuback Vein Center.

Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. -

____

Patient Signature: ________________________ Date:____________________

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