Atlantic Shore Surgical Associates

478 Brick Blvd, Brick NJ 08723
Phone: 732-701-4848 Fax: 732-701-1469

PATIENT RESPONSIBILITY
FOR FOLLOW-UP CARE PLEDGE

I, _____(print last name),_____ (print first name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Signature_____ Date _____

ATLANTIC SHORE SURGICAL ASSOCIATES

478 BRICK BLVD.
BRICK, NJ 08723-6077
PHONE: (732) 701-4848 FAX: (732) 701-1469

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of individual's home.

I wish to be contacted in the following manner (check all that apply)

__Home telephone # _____
__ ok to leave message with detailed information
__ leave message with call back number only

__ Work telephone # _____
__ ok to leave message with detailed information
__ leave message with call back number only
__ other _____
_____
_____

__Written communication
__ ok to mail to home address
__ ok to mail to my work address
__ ok to fax to this number _____

__Persons authorized to receive info
_____ relationship _____
_____ relationship _____
_____ relationship _____

By signing this document, I acknowledge that I have received a copy of the Atlantic Shore Surgical Associates, P.A. notice of privacy practices.

Patient's Signature: _____ Date: _____

Patient's Name (print): _____ Date of Birth: _____

Parent/Guardian Signature (if patient is under 18): _____

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

Referring Physician: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Chief Complaint: _____

History of present illness:

- **Location** _____ (Where is the pain/ problem?)
- **Severity** _____ (How severe is the pain/problem on a scale of 1-5? 5 being the most severe)
- **Timing** _____ (Does the pain/problem occur at a specific time?)
- **Quality** _____ (Example: normal vs. abnormal color, activity,etc)
- **Duration** _____ (How long have you had this pain/ problem? Or when did it start?)
- **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?)

MEDICAL HISTORY:

Patient Medical History:

Diabetes	NO	YES
Hypertension	NO	YES
Cancer	NO	YES
Stroke	NO	YES
Heart Trouble	NO	YES
Arthritis/ Gout	NO	YES
Convulsions	NO	YES
Bleeding tendency	NO	YES
Acute infections	NO	YES
Venereal disease	NO	YES
Hereditary disease	NO	YES

Previous Hospitalizations/ Surgeries/ Serious Injuries **When?**

_____
_____
_____
_____
_____

Medications:

_____
_____
_____

Last menstrual period: _____

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	DISEASE	If Deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____
	____	_____	_____

REVIEWED BY: _____ **DATE:** _____
(For Physician Signature Only)

Review of Systems: ***Please indicate any personal history below.***

CONSTITUTIONAL SYMPTOMS

Good general health lately	N Y
Recent weight change	N Y
Fever	N Y
Fatigue	N Y
Headaches	N Y

EYES

Eye disease or injury	N Y
Wear glasses/ contact lenses	N Y
Blurred or double vision	N Y
Glaucoma	N Y

EARS/ NOSE/ MOUTH/ THROAT

Hearing loss or ringing	N Y
Earaches or drainage	N Y
Chronic sinus problem or rhinitis	N Y
Nose bleeds	N Y
Mouth sores	N Y
Bleeding gums	N Y
Bad breath or bad taste	N Y
Sore throat or voice change	N Y
Swollen glands in neck	N Y

CARDIOVASCULAR

Heart trouble	N Y
Chest pain or angina pectoris	N Y
Palpitation	N Y
Shortness of breath w/ walking	N Y
Swelling of feet, ankles or hands	N Y

RESPIRATORY

Chronic or frequent coughs	N Y
Spitting up blood	N Y
Shortness of breath	N Y
Asthma or Wheezing	N Y

GASTROINTESTINAL

Loss of appetite	N Y
Change of bowel movements	N Y
Nausea or vomiting	N Y
Frequent diarrhea	N Y
Painful bowel movements	N Y
Constipation	N Y
Rectal bleeding or blood in stool	N Y
Abdominal pain	N Y
Peptic ulcer (stomach or duodenal)	N Y

GENITOURINARY

Frequent urination	N Y
Burning or painful urination	N Y
Blood in urine	N Y
Incontinence or dribbling	N Y
Kidney Stones	N Y
Sexual difficulty	N Y
Male ~ testicle pain	N Y
Female~ painful periods	N Y
Female~ irregular periods	N Y
Female~ vaginal discharge	N Y
Female # of pregnancies _____	
Female # of miscarriages _____	
Female ~ date of last pap smear _____	

MUSCULOSKELETAL

Joint pain	N Y
Joint stiffness or swelling	N Y
Weakness of muscles or joints	N Y
Muscle pain or cramps	N Y
Back pain	N Y
Cold extremities	N Y
Difficulty in walking	N Y

INTEGUMENTARY (skin, breast)

Rash or itching	N Y
Change in skin color	N Y
Varicose veins	N Y
Breast pain	N Y
Breast Lump	N Y
Breast discharge	N Y

NEUROLOGICAL

Frequent or recurring headaches	N Y
Light headed or dizzy	N Y
Convulsions or seizures	N Y
Numbness or tingling sensations	N Y
Tremors	N Y
Paralysis	N Y
Stroke	N Y
Head injury	N Y

PSYCHIATRIC

Memory loss or confusion	N Y
Nervousness	N Y
Depression	N Y
Insomnia	N Y

ENDOCRINE

Glandular or hormone problem	N Y
Thyroid disease	N Y
Diabetes	N Y
Excessive thirst or urination	N Y
Heat or cold intolerance	N Y
Skin becoming dryer	N Y
Change in hat or glove size	N Y

HEMATOLOGICAL/ LYMPHATIC

Slow to heal after cuts	N Y
Bleeding or bruising tendency	N Y
Anemia	N Y
Phlebitis	N Y
Past transfusion	N Y
Enlarged glands	N Y

ALLERGIC/ IMMUNOLOGIC

History of skin reaction or adverse reaction to:

Penicillin	N Y
Morphine, Demerol, other Narcotic	N Y
Novocaine or other anesthetics	N Y
Aspirin	N Y
Tetanus antitoxins or other serums	N Y
Iodine, Methiolate, other antiseptic	N Y
LATEX	N Y

Other drugs/ medications: _____

Known food allergies: _____

Environmental allergies: _____

Reviewed by: _____ _____ ***Date:*** _____

(For Physician Signature Only)

Diet History

Please be as detailed and specific as possible. Most insurance companies will require the following information.

How many years have you been overweight? _____

Lowest adult weight? _____ Highest adult weight? _____

Type of weight loss program	Dates	Number of times tried?	How long did you follow the diet?	Total weight Loss

Examples: Weight Watchers, Self diet (low calorie, low carb), Jenny Craig, Atkins, South Beach, Paleo, Optifast, Isagenix, Nutrisystem, diet pills, HCG