North American
HEROES MEDICAL

PATIENT INFORMATION

Today's Date: ____/____/_____	Date of Birth and Gender: (Circle) ____/____/_____ M F	Email Address: Pharmacy:	Insured's ID Number: SS# of patient: SS# of insured:
Patient's Name:		Insured's Name: (Write SAME if patient is policy holder)	
Patient's Address:	Apt.	Insured's Address: (Write SAME if patient is policy holder)	
City:	State:	City:	State:
Zip Code:	Home Phone: ( )	Cell Phone: ( )	Zip Code:
Insured's Home Phone: ( )	Insured's Cell Phone: ( )		
Patient's Employer Name or School Name:		Primary Insurance (Insured's Group or FECA Number)	
Employer or School Phone: ( ) Ext:	( ) Ext:	Insured's (Policy Holder's) Date of Birth: ____/____/_____	Gender: M F
Secondary or Other Insurance Policy Holder Name:	Patient Relationship to Insured: (Circle) Self Spouse Child Other	Insured's Employer or School Name:	
Secondary or Other Insurance Policy/Group Name:	Patient Status: (Circle) Single Married Other	Insurance Plant Name or Program Name:	
Secondary Policy Holder's Date of Birth and Gender: ____/____/_____ (Circle) M F	Employed: (Circle) Current Previous	Is there another health benefit plan? Y N If yes, please complete other insurance information	
Secondary Insurance Plant Name or Program Name:	Student: (Circle) Full-time Part-time	Whom should we thank for referring you?	
If patient has representative, print name, relationship to patient and contact phone(s):			
Emergency Contact / Relationship to Patient		Work Phone: ( )	
Home Phone: ( )		Cell Phone: ( )	

ASSIGNMENT OF BENEFITS

Name of Insured:

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed before for any services, supplies or equipment provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable or related services or equipment to the organization, the Center of Medicare and Medicaid Services (CMS), my insurance carrier or other medical entity. A copy of this authorization will be sent to my CMS, my insurance company or other entity if requested. The original authorization will be kept on file by my organization.

I understand that I am financially responsible to the organization for any charges that are not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/ or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained for all payment products received.

Organization: North American Heroes Medical

Name of Patient or Representative: (print)	Relationship to Patient:
Signature of Patient:	Date:

North American
HEROES MEDICAL

CONFIDENTIAL HEALTH HISTORY QUESTIONAIRE

Name: _____ **Gender:** ☐ M ☐ F DOB: ____/____/_____ **Date:** ____/____/_____

Last Physical Exam Was: ____/____/_____ **Any Prior HX of Surgery**? ☐ YES ☐ NO _____

Reason for the Visit: _____

Symptoms Check (✓) if you currently have or had in the past year.

GENERAL
- ☐ Chills R68.83
- ☐ Depression F68.8
- ☐ Dizziness R42
- ☐ Fainting R55
- ☐ Fever R50.4
- ☐ Headache R51
- ☐ Loss of Sleep F51.09
- ☐ Weight Loss R13.4
- ☐ Anxiety F41.9
- ☐ Numbness
- ☐ Sweating
- ☐ Seizures
- ☐ Others: _____

_____
_____
_____

GASTROINTESTINAL
- ☐ Poor Appetite R6.0
- ☐ Bloating
- ☐ Constipation K590
- ☐ Diarrhea R19.7
- ☐ Excessive Hunger T73.0
- ☐ Excessive Thirst E86.0
- ☐ Gas Pain R14.1
- ☐ Hemorrhoids K64.0
- ☐ Nausea R11.0
- ☐ Rectal Bleeding
- ☐ Stomach Pain G89.1
- ☐ Abdominal Pain
- ☐ Vomiting G43.A0
- ☐ Vomiting Blood
- ☐ Others: _____

_____

EYE EAR NOSE THROAT
- ☐ Bleeding Gums
- ☐ Blurry Vision H53.3
- ☐ Crossed Eyes H55.00
- ☐ Double Vision H53.3
- ☐ Earache Z01.1
- ☐ Ear Discharge H60.00
- ☐ Hay Fever J01.9
- ☐ Hoarseness
- ☐ Nosebleeds J34.9
- ☐ Persistent Cough R05
- ☐ Hearing Loss Z82.2/H91.20
- ☐ Ringing in Ears H9319
- ☐ Sinus Problems J01.9
- ☐ Vision Problems H53.9
- ☐ Others: _____

_____

MEN ONLY
- ☐ Breast Lump N63
- ☐ Erectile Dysfunction N52.9
- ☐ Testicular Pain N50.819
- ☐ Penis Discharge R36.9
- ☐ Sore on Penis N48.5
- ☐ Swollen Scrotum S30.94

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding N94.6
- ☐ Breast Lump N63
- ☐ Menstrual Pain N94
- ☐ Hot Flashes
- ☐ Nipple Discharge N64.52
- ☐ Painful Intercourse N94.1
- ☐ Vaginal Discharge R36.9
- ☐ Others: _____

JOINT/MUSCLE/BONE
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

CARDIOVASCULAR
- ☐ Chest Pain R07.9
- ☐ Hypertension I10
- ☐ Low Pressure I95.9
- ☐ Irregular Pulse I49.9
- ☐ Palpitation R00.2
- ☐ Ankle Swelling
- ☐ Varicose Veins I83.90
- ☐ Others: _____

SKIN
- ☐ Bruise Easily
- ☐ Hives
- ☐ Change in Moles R23.4
- ☐ Itching L29.9
- ☐ Rash L30.9
- ☐ Scars L91.9
- ☐ Sores that won't heal
- ☐ Others: _____

Date of Last Menstrual ___/___/____
Had a Mammogram? _____
Pap Smear Date: _____
Pregnant? _____
No. of Children: _____

GENITOURINARY
- ☐ Blood in Urine R31.0
- ☐ Frequent Urination R35.0
- ☐ No Bladder Control R39.81
- ☐ Painful Urination R30.0

ALLERGIC TO WHAT?
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

CHECK (✓) IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- ☐ Alcoholism
- ☐ Anorexia
- ☐ Bulimia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Golter
- ☐ Gonorrhea
- ☐ Pacemaker
- ☐ Chemical Dependency
- ☐ Appendicitis
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Emphysema
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Arthritis
- ☐ Cataract Surgery
- ☐ Liver Disease
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Pneumonia or TB
- ☐ Prostate Problems
- ☐ Bleeding Disorders
- ☐ Chickenpox
- ☐ Psychiatric Problems
- ☐ Glaucoma
- ☐ Prostate Problems
- ☐ Herpes Zoster
- ☐ Venereal Disease
- ☐ Anemia
- ☐ Breast Lump
- ☐ HIV-Positive
- ☐ Scarlet Fever
- ☐ Migraine
- ☐ Gout
- ☐ Hernia
- ☐ Thyroid Fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Measles
- ☐ Stroke
- ☐ Ulcers
- ☐ Mumps
- ☐ Hepatitis
- ☐ MS

LIST OF MEDICATIONS YOU ARE TAKING NOW: _____

HOSPITALIZED FOR? _____

North American
HEROES MEDICAL

Medical Qualification Form

Patient's Name: _____ Date of Birth: ____/____/_____

Are you currently taking any blood pressure medication? ☐ YES ☐ NO

If YES, please list: _____

Do you have a history of Cardiovascular Disease and/or are you currently taking any Cardiac medicine? ☐ YES ☐ NO

Do you have a history of any Immune System Disorders? (EX: Cancer, HIS, etc.) ☐ YES ☐ NO

Have you ever had an anaphylactic reaction that required emergency medical attention? ☐ YES ☐ NO

Are you a moderate/severe asthmatic or have a history of respiration disease? ☐ YES ☐ NO

Within the past year, have you had an Allergy Scratch Test? ☐ YES ☐ NO

Within the past year, have you had Immunotherapy Medication made for you? ☐ YES ☐ NO

Do you have a history of taking any allergy medications including allergy shots? ☐ YES ☐ NO

If YES, please list: _____ Last used: ____/____/_____

Do you have a history of taking any steroids? (Oral, inhaled, or topical) ☐ YES ☐ NO

If YES, please list: _____ Last used: ____/____/_____

Are you pregnant? ☐ YES ☐ NO

*If there is any possibility that you are pregnant, please notify the physician before you have the allergy test.

Physician's Notes:

_____

_____

_____

_____

Patient's Signature: _____ Date: ____/____/_____

Physician's Signature: _____ Date: ____/____/_____

Patient ID# (Staff use only): _____

North American
HEROES MEDICAL

Allergy and Asthma Screen

Please fill out and hand to Medical Assistant in the exam room.

Patient name	Date of birth	Today's date

How often do you have these symptoms?

(Please check one box in the Severity section and Frequency section)

	SEVERITY			FREQUENCY		
	Mild	Moderate	Severe	Never or Occasionally	Seasonal	Most of the Year/Daily
Itchy/Watery/Red Eyes	☐	☐	☐	☐	☐	☐
Runny/Stuffy/Itchy Nose	☐	☐	☐	☐	☐	☐
Frequent Sneezing	☐	☐	☐	☐	☐	☐
Post Nasal Drip	☐	☐	☐	☐	☐	☐
Chronic/Seasonal Colds	☐	☐	☐	☐	☐	☐
Sinus Pressure/Sinus Headache	☐	☐	☐	☐	☐	☐
Dry, Red, or Itchy Skin	☐	☐	☐	☐	☐	☐
Consistent Coughing	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Itchy Mouth / Throat Clearing	☐	☐	☐	☐	☐	☐
Restless Sleep / Snoring	☐	☐	☐	☐	☐	☐
Daytime Fatigue	☐	☐	☐	☐	☐	☐

How often do you use the following?

	Never or Occasionally	Seasonal	Most of the Year/Daily
Over-the-Counter Antihistamine (Allegra®, Claritin® Zyrtec®, Benadryl®, etc)	☐	☐	☐
Over-the-Counter Cold Meds	☐	☐	☐
Over-the-Counter Nasal Spray	☐	☐	☐
Prescribed Allergy Medication/Spray	☐	☐	☐
Neti Pot	☐	☐	☐
Inhaler	☐	☐	☐

Patient/Guardian signature	Date	Patient phone

FOR PROVIDER USE ONLY:

Order Allergy Test: ☐ Yes ☐ No

Date of last Physical exam: ___/___/_____

Provider signature: _____

Date: ___/___/_____

North American
HEROES MEDICAL

CONSENT FOR OUTPATIENT TREATMENT AUTHORIZATION

1. I hereby authorize the hospital, the physicians, dentists, and other health care professionals to provide such medical care and to administer such treatment, including immunizations as deemed necessary or advisable to me or the named patient each time I or the named patient present to an ambulatory care service. To the extent possible I have been informed of risks and complications that may occur and that may be available.

2. I acknowledged that no guarantees or assurances have been made to me concerning the results intended for my treatment.

MEDICARE PATIENTS

3. I authorize any holder of medical or other information about me to release the Social Security Administration, its intermediaries or carriers of any information needed for this or related Medicare class. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

GUARANTEE OF ACCOUNT

4. For and inconsideration of service rendered to (name) _____ by the faculty hereby agree to pay the full bill for all the charges, which are not covered Blue Cross, workers' compensation, or any balance due which is not covered by insurance or excluded by a co-insurance clause.

RELEASE OF INFORMATION

5. I permit the hospital to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for the collection of benefits or payment of hospital charges.

ASSIGNMENT OF BENEFITS

6. I assign to the hospital all benefits from any corporation, agencies, and person for these services. I authorize payments of these benefits directly to the hospital.

7. I confirm that I have read and fully understand the above.

Patient/Relative or Guardian: _____ _____

Print Name Signature

Relationship: (If signed by person other than the patient) _____

(if required) Interpreter: _____

Witness: _____ _____ _____

Print Name Signature Date

North American
HEROES MEDICAL

HIPPA FORM

North American Heroes Medical would like you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow North American Heroes Medical to use their Patient Health Information (PHI) for the purpose of treatment, payment healthcare operations, and coordination of care. As an example, the patient agrees to allow North American Heroes Medical to submit requested PHI to the health insurance company provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of PHI to the minimum needed for what insurance companies require for payment.

2. The patient has the right to obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosure has been made ad submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's consent needs only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in the office. We have taken all precautions that are known by the office to assure that your records are not readily available to those who do not need them.

6. Patients have full rights to file a formal complaint with our privacy official about any possible violations of this policy and its procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment, and or health care operations, the doctor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and agree to these policies and procedures.

_____	_____	_____
Name of Patient	Signature	Date

North American
HEROES MEDICAL

PRIVACY NOTICE

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 CREAFULLY.

Effective April 14th, 2003

The privacy of your medical information is important to us. You may be aware that U.S. government regulations established privacy rule (HIPPA) governing protected health information. This notice tells you about how it may be used, and about certain rights that you have. _____ oversees privacy maters at your facility. You can contact him/her at _____ if you desire to have any questions or concerns.

USE AND DISCLOSURE OF PROTECTED INFORMATION

Federal law provides that we may use your medical information (Protected Health Info) for treatment of you without further notice to you; for example; we may send your referring physician a copy of your initial evaluation or a periodic progress report to let them know how your care is progressing. Federal law provides that we may use your PHI for healthcare operations without further notice to you, or written authorization by you; for example; our accountants may see your name, dates or treatments and procedure codes during audits of our records. We may use or disclose your medical information, without further notice to you, or specific authorization by you. Required by law, for public health purposes, in judicial or administrative proceedings, to report child abuse, by health oversite agency for oversite activities. Authorized by law, such as the Department of Health, Office of Professional Discipline Medical Conduct. Permitted by law to a funeral director, law for organ donation purposes, to avert a serious threat to health or safety, by military authorities if you are a member of the armed forces of the United States, and for research purposes. New Jersey law provides additional protection for information regarding HIV/AIDS. We will continue with New Jersey State law with respect to such information. We may contact you by email, text message, or phone at your residence, or on your cellular phone to remind you of appointments or to provide information about treatment alternatives. Unless you instruct otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence. You can make reasonable request, in writing, for us to use alternative methods of communication with you in a confidential manner. Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

RIGHTS THAT YOU HAVE

You have the right to request restrictions on some of the uses or disclosures described on the previous document. Except as stated below, we are not required to agree to such restrictions. You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to your medical information. Such requests must be in writing and must state the reason for the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request accounting of any disclosures we make of your medical information, except for disclosures we make to you, to carry out treatment, payment, or health care operations, or as requested by your written authorization, or as permitted of required under 45 CFR 164.502 or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosure made before April 14th, 2003.

OBLIGATIONS WE HAVE

We are required by law to maintain the privacy of protected health information and to provide individuals with noticed of our legal duties and our privacy policies. We are required to abide by the terms of this notice as long as it is currently in effect. We reserve the right to revise this notice and make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our facility, and copies will be available here. If you want to file a complaint about violations of your privacy right, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints will be directed to _____. No retaliatory.

Signature: _____ Date: _____