PATIENT REGISTRATION INFORMATION

FIRST NAME ______________________ LAST NAME ___________________________ BIRTH DATE _____________ AGE ___

ADDRESS ____ CITY ________________________ STATE ___ ZIP __________

CELL # ____________________________ HOME # _____________________________ WORK # _______________________

SEX: M _____ F _____ SSN # _______ - _______ - _______ MARITAL STATUS S / M / D / W

PATIENT`S EMPLOYER ____

ADDRESS ____ CITY ________________________ STATE ___ ZIP __________

EMAIL ADDRESS ____ (for patient portal)

PHARMACY NAME ____ PHONE # ___________________________

ADDRESS ____ RX CARD # ________________________

PRIMARY INSURANCE ____

POLICY/ID # ____ GROUP # ___________________________________

SUBSCRIBER NAME ____ DOB: ___________ RELATIONSHIP _____________

EMPLOYER ____

ADDRESS ____ CITY ________________________ STATE ___ ZIP __________

SECONDARY INSURANCE ____

POLICY/ID # ____ GROUP # ___________________________________

SUBSCRIBER NAME ____ DOB: ___________ RELATIONSHIP _____________

EMPLOYER ____

ADDRESS ____ CITY ________________________ STATE ___ ZIP __________

EMERGENCY CONTACT INFORMATION: NAME ____

PHONE ________________________________ ADDRESS ____

WHOM MAY WE THANK FOR REFERRING YOU? ____

HEALTH HISTORY

FIRST NAME ______________________________ LAST NAME ___________________________ BIRTH DATE ____________

Allergies ____

____

SOCIAL HISTORY

Marital status: Single Married/Separated Divorced Widowed

Occupation: ____ Children: ___________________

Alcohol: Current Past Never Drink/day or week _______________________

Smoking: Current Past Never What age started/ stopped __________ pack/day ______

Recreational Drug Use: Current Past Never

Excessive exposure: Fume Dust Solvents Noise Airborne Particle

List all MEDICATIONS you take including over the counter (OTC) medications and vitamins. Include doses and when taken.

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____

____

____

Immunization (year last received)

Tetanus __________ Influenza __________ Hepatitis B __________ Pneumonia _________ Herpes Zoster_________

PERSONAL MEDICAL HISTORY (please circle/ fill in all that apply)

ADHD COPD High Cholesterol Peptic Ulcer Alcoholism Dementia HIV Psoriasis Allergy, seasonal

Depression Hepatitis Pulmonary Embolism (PE) Anemia Diabetes 1 or 2 Irritable Bowel Syndrome

Rheumatoid Arthritis Anxiety Diverticulosis Kidney Disease/UTI Sciatica Arrhythmia DVT (blood clot)

Kidney stones Seizure Disorder Arthritis Eczema Lupus Sleep Apnea Asthma Emphysema Liver

Disease Stroke Bipolar Disorder Gallstones Macular Degeneration Thyroid Disorder

Bladder Incontinence GERD Migraine Ulcerative Colitis Bleeding Problems Glaucoma Nosebleeds

Chickenpox Cancer _____ Heart Disease Neuropathy Pneumonia Carpal Tunnel Heart Attack (MA)

Osteopenia/Osteoporosis Hepatitis A/B/C Headaches Hiatal Hernia Parkinson`s Disease Measles

Crohn's disease High Blood Pressure Peripheral Vascular disease TB

Other medical problems not listed above: ____

____

Last Menstrual Period YES/NO Date ____________ Normal/Abnormal

Colonoscopy YES/NO Date ____________ Normal/Abnormal

Mammogram YES/NO Date ____________ Normal/Abnormal

DEXA/Bone Density YES/NO Date ____________ Normal/Abnormal

SURGICAL HISTORY: please list all surgeries and approximate dates performed:

____

____

____

FAMILY HISTORY:

FATHER: living Age _______ Deceased Age _______

Alcoholism Blood Cancer Migraine Osteoporosis COPD/Emphysema Skin Cancer High Cholesterol

Colon Cancer Heart Disease Bleeding Problems Thyroid Problems Thyroid Disorder Thyroid cancer

Asthma dementia Heart Attack DVT (blood clot) Depression Prostate cancer Kidney Disease

Arthritis High Blood Pressure Diabetes 1 or 2 Stroke Anemia

Other ____

Paternal Parents: ____

MOTHER: living Age _______ Deceased Age _______

Alcoholism Blood Cancer Migraine Osteoporosis COPD/Emphysema Skin Cancer High Cholesterol

Colon Cancer Heart Disease Bleeding Problems Thyroid Problems Thyroid Disorder Thyroid cancer

Asthma dementia Heart Attack DVT (blood clot) Depression Prostate cancer Kidney Disease

Arthritis High Blood Pressure Diabetes 1 or 2 Stroke Anemia

Other ____

Maternal Parents:
____

SIBLINGS: ____

LIST OTHER PROVIDERS YOU SEE ON REGULAR BASIS (I.E. Cardiologist, Pulmonologist, etc.)

____

____

____

Patient (Guardian/Parent) signature ____ Date __________________

Assignment and Release:

I, the undersigned, certify that I, or my dependent, have insurance coverage with insurance carriers listed above and assign all insurance benefits directly to Tatyana Ponti MD, PC. If benefits are paid to me, it is my responsibility to reimburse Tatyana Ponti MD, PC.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that I am responsible for providing all necessary information about my insurance company as well as referrals if it is required by my insurance plan, otherwise I will be financially responsible for all charges.

General Consent for Diagnosis, Care, and Treatment:

I the undersigned, on an ongoing basis request consent and authorize Tatyana Ponti, Md to provide care, testing and treatment as determined necessary. I understand that I may ask my healthcare providers about my care, treatment and procedures at any time and am encouraged to do so.

Consent and Authorization to Use and Disclose Health Information:

Tatyana Ponti, Md maintains health records in electronic and other forms. These records describe, among other things, my past and current health status, including diagnosis, results of exams and tests, treatment provided and any plans of care. In addition, these records include billing, social and other identifying information and may include sensitive information such as genetic testing, HIV/AIDS status, and drug or alcohol use. I authorize Tatyana Ponti, MD when necessary for treatment or payment to release and exchange my Health Information with other providers or organizations involved in my care for the same reasons.

Consent to Treat Chronic Condition (s) : x`

If you have two or more conditions that are not expected to be resolved within a year or lifetime that require prescription renewals, coordinating care with other healthcare providers, phone consults, review of test results, contacting insurancecompanies, etc.; these conditions will be treated by Tatyana Ponti MD. This is not concierge service, and you are not financially responsible for this treatment. Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will participate in this program.

Tatyana Ponti, Md participates in many Quality-of-Care programs. If you receive a notification from your insurance company that you do not understand, please call the office. You are not financially responsible for any of these services although your insurance company may indicate a co-pay or co-insurance.

Acknowledgment of Receipt of Privacy Notice:

I hereby acknowledge that I have reviewed or received a copy of Tatyana Ponti, MD Privacy Notice.

Signature______________________________ **Date**___/____/_________

tp Tatyana Fast-Ponti, MD

Diplomat, American Board of Internal Medicine I Affiliated, American Academy of Dermatology

160 White Road #102 Little Silver, NJ 07739 Tel: 732.450.0062 Fax: 732.450.0616

Consent for Services Initiated thru Patient Portal

I authorize Dr. Tatyana Ponti, to evaluate and or assess any condition that I inform her of thru the Patient Portal. I understand that I must provide to her accurate information regarding any symptoms, send photos, copies of reports, etc. thru the Patient Portal.
Dr. Ponti will then review the information and call you. At that time, she will advise you if your complaints will require an office visit or provide instructions, prescriptions, or test orders as necessary.

We urge you to utilize your Patient Portal to communicate with Dr. Ponti. Although in some instances you will need to be physically examined, many of your questions and concerns can be addressed by contacting Dr. Ponti directly through the portal.

Name___________________________________

Date of Birth_____________________________

Phone___________________________________

Signature_________________________________

PRIVACY NOTICE

1. Your confidential healthcare information may be released to other healthcare professionals for the purpose of providing you with quality healthcare. This includes other providers involved in your care.

2. Your confidential healthcare information may be released to your insurance provider for the purpose of receiving payment for providing you with needed healthcare services.

3. Your confidential healthcare information may be released to the public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

4. Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.

5. Your confidential healthcare information may be released to a public health organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).

6. You may be contacted by the staff of Tatyana Ponti, MD to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

7. You have the right to restrict the use of your confidential healthcare information. However, Tatyana Ponti, MD may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

8. You have the right to receive confidential communication about your health status.

9. You have the right to review and photocopy any/all portions of your healthcare information.

10. You have the right to request amendments to your healthcare information.

11. You have the right to know who has accessed your confidential healthcare information and for what purpose.

12. You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

13. Tatyana Ponti, MD will notify patient (s) if a reportable breach is discovered. Notification will be made to patient (s) as soon as possible but no later than 60 days from the time the breach is discovered. Notification will include a brief description of how breach occurred, a description of PHI involved, and steps patient (s) should take to protect themselves from harm. This notification will also include contact information for the individual to ask questions.

14. Tatyana Ponti, MD shall abide by the terms of this notice.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(HIPAA COMPLIANT)

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIP AA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

All physical, occupational and rehab requests, consultations, and progress notes.

All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels, and reports.

All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information to:

Dr. Tatyana Ponti MD, PC 160 White Rd, Suite 102, Little Silver, NJ, 07739, Tel: 732-450-0062, Fax: 732-450-0616

This authorization may be revoked by me at any time except to the extent that Dr. Tatyana Ponti MD, PC has already acted in reliance on this authorization. If I revoke this authorization, it must be in writing and mailed or hand delivered to the medical office of Dr. Tatyana Ponti MD, PC.

Patient name ____ DOB: _________

Patient signature ____ Date: _________