ESA SOUTH JERSEY BARIATRICS

Patient Name: _____ **Date of Birth**: _____ **Gender**: M F

Street Address: _____

City: _____ **State**: _____ **Zip Code**: _____ **SS#**: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ **Email: _____**

Marital Status: Single Married Divorced Separated Widowed

Race: Asian Black/African American White/Caucasian Other: _____ Declined

Ethnicity: Hispanic Non-Hispanic Declined

Employer: _____

Employer Address: _____

Pharmacy Name & Address: _____ Phone #: _____

Primary Care Doctor Name: _____ Phone #: _____

PRIMARY INSURANCE CARRIER: _____

Insurance Company Address: _____

Subscriber for Insurance: _____ Subscribers DOB: _____

Subscribers SS#: _____ Subscribers Employer: _____

SECONDARY INSURANCE CARRIER: _____

Insurance Company Address: _____

Subscriber for Insurance: _____ Subscribers DOB: _____

Subscribers SS#: _____ Subscribers Employer: _____

Emergency Contact: _____ Phone: _____ Relatinship:_____

I certify the information provide above is correct. My signature on this form authorizes the release of medical information necessary to process insurance claims to your insurance company and or their agencies as required or necessary for claims processing and payment. By signing below, I authorize payment for claim to be directly dispersed to ESA South Jersey Bariatrics and or its providers of service. I am aware that any charges deemed payable by me according to my insurance policy and processing of claim will be my responsibility. I have been informed that interest will accrue on unpaid balances and that all past due balances without payment monthly will be sent to a collection agency. (I permit a copy of this to be used in place of original as needed.)

Patient Signature Required: _____ Date: _____

ESA SOUTH JERSEY BARIATRICS

MEDICAL HEALTH HISTORY

Patient Name: _____ DOB: _____

What current symptom, problem or reason are you here for today?

_____

_____

_____

Do you have any **Drug Allergies**? NO YES

If yes Drug Name: _____ Reaction: _____

Do you have any **Non-Drug Allergies**? NO YES

If yes Drug Name: _____ Reaction: _____

MEDICATIONS (You are currently taking)

DRUG NAME	DOSE	CONDITION / REASON FOR TAKING

IF YOU ARE NOT TAKING ANY MEDICATION CHECK HERE _____I AM CURRENTLY NOT TAKING ANY MEDICATIONS.

PAST MEDICAL HISTORY: Please Circle all that apply

Arthritis: Osteoporosis Rheumatoid
Asthma / COPD
Bowel / Bladder Abnormalities
Cancer type: _____
Chest Pain / Angina
Diabetes: Type I Type II
Diarrhea
Diverticulitis
Dizziness / Fainting
Gall Bladder Problems
GERD / Reflux
Headaches
Heart Disease
Heart Palpitations
Hemorrhoids
Hernia
High Cholesterol
Hypertension
Kidney Problems
Liver Problems
Implants: Type_____
Pain: Arm Back Knee Leg
Seizures
Sleep Apnea
Stroke / CVA / TIA
Thyroid Disease
Other: _____

Is there any other past health information we should know about?

_____

SURGICAL HISTORY

TYPE OF SURGERY	DATE WHEN PERFORMED	SURGEONS NAME

FAMILY HISTORY

CONDITIONS	MOTHER	FATHER	SISTER	BROTHER	AT WHAT AGE?
Arthritis Osteoporosis Rheumatoid					
Cancer: Type					
Depression					
Diabetes Type 1 (childhood onset)					
Diabetes Type 2 (adult onset)					
Epilepsy (seizures)					
Heart Disease: Heart Attack or Coronary Artery					
High Cholesterol (Hyperlipidemia)					
High Blood Pressure (Hypertension)					
Kidney Disease					
Migraine Headaches					
Stroke / TIA					
Thyroid Disease					

SOCIAL HISTORY: Must answer all questions below (Circle all that apply)

Circle One: Employed Unemployed Homemaker Student Retired Disabled

Employer: _____

Occupation: _____ **Status**: Full-time Part-time

Marital Status: Single Married Separated Divorced Widowed

Number of Children you have: _____

Hobbies Recreation: *circle all that apply*

Board Games	Fishing	Painting	Shopping
Boating	Gardening	Photography	Traveling
Crafts	Hunting	Reading	Watching TV
Card Games	Motor Cycling	Sports: Watching	Walking
Computer Games	Musical Instrument	Sports: Playing	

Exercise: *circle all that apply*

Aerobics Cross-Training Cycling Dancing Running Swimming Walking
Weight lifting OTHER: _____

How often do you exercise?

Weekly (How many days?) 1 2 3 4 5 6 7

Time in Minutes: 15 20 25 30 35 40 45 50 55 60

VACCINATION RECORD

Vaccination Type	YES or NO	WHEN	WHERE
Flu Vaccination	YES NO		
Pneumonia Vaccination	YES NO		

Covid 19 Vaccination	Not Vaccinated	I have chosen not to be vaccinated for personal reasons	
Vaccination Type	BRAND TYPE	YES or NO	When & WHERE
Covid 19 Vaccination	Pfizer	YES NO	
Covid 19 Vaccination	Moderna	YES NO	
Covid 19 Vaccination	J & J Janssen	YES NO	
Covid 19 Vaccination	Booster	YES NO	

Do you have any Cultural/Religious Customs / Barriers? NO YES

if yes list: _____

Do you have any impairments? NO YES *Circle applicable* Learning Hearing Physical Speech Vision

Do you have an Advance Directive? YES NO if No Would you like Information? NO YES

Do you have a Living Will? YES NO if No Would you like Information? NO YES

TOBACCO & ALCOHOL USE

Are you currently a smoker? YES NO *Circle applicable* Cigar Cigarettes Vaping **How often**?

_____

Do you drink Alcohol? Yes NO *Circle applicable* Beer Wine Mixed Drinks **How often**?

_____

SUPPLEMENTS: Appetite Suppressants Ginseng Fat-burners Multivitamins
Other_____

SUBSTANCE ABUSE HISTORY:

Do you currently use recreational drugs? *Circle applicable* Cocaine Heroin Marijuana Other: _____

Have you had or do you have any drug addiction? YES NO Amphetamines Barbiturates Heroin Cocaine

List any other recreational drugs you are using: _____

MENTAL HEALTH HISTORY: *Have you ever been diagnosed with any of the following disorders?*

Anxiety Disorder	NO	YES	Type:	When:
Eating Disorder	NO	YES	Type:	When:
Mood Disorder	NO	YES	Type:	When:
Personality Disorder	NO	YES	Type:	When:
Sleep Disorder	NO	YES	Type:	When:

COMMUNICALBE DISEASE HISTORY: Have you ever been diagnoses with any of the following: *Circle all that apply*

AIDS Gonorrhea Hepatitis A Hepatitis B Hepatitis C Herpes

HIV HPV Measles Mumps Syphilis TB/Tuberculosis

ESA South Jersey Bariatrics

Patient Portal Authorization Agreement

Name: _____ Account number: _____

Email: _____

Purpose of this Form

ESA South Jersey Bariatrics offers secure electronic access to your medical record and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

How to Participate

You may compose, pick up, and reply to secure messages or view information sent to you through the Patient Portal. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal, we will assign you a username and password. You may then login to the Patient Portal through our website at http://www.esasjbariatrics.com or directly by going to www.gotomyclinic.com/esasjbariatrics.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information. If you believe someone has learned your password, you should immediately go to the Web site and change it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the Patient Portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. Please read our Notice of Privacy Practices for additional information on uses and disclosures.

Conditions of Participating in the Patient Portal

Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service we will notify you as promptly as we reasonably can. You agree to not hold ESA South Jersey Bariatrics or any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with

our policies and procedures, do not sign this agreement and do not request a username and password. If you have questions we will gladly provide more information.

Patient Acknowledgement

Patient Signature_____ Date: _____

Authorization for Release of Information

Name: _____Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Cell: _____

_____ I authorize ESA South Jersey Bariatrics to release information to:

_____ I authorize the release for information to ESA South Jersey Bariatrics from:

Name of Provider of Facility	
Address	
City, State, Zip Code	
Fax	
Telephone	

PURPOSE OF THIS REQUEST: _____Healthcare _____ Insurance Coverage _____Personal Other: _____

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ Assessments ☐ Progress Notes ☐ Laboratory Test Results:
☐ Diagnostic Impression ☐ Discharge Summary ☐ Treatment Plans
☐ Treatment Summary ☐ Drug/Alcohol Treatment & Evaluation
☐ Psychiatric/Psychological Treatment & Evaluation
☐ Other: (please describe)_____

This authorization will expire: (Select One)
____ When I am no longer receiving services from ESA SJ Bariatrics.
_____ One time use for this requested information Once requested information has been sent or received.

I understand that:
I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
I may cancel this authorization at any time by submitting a written request to the ESA SJ Bariatrics, except where a disclosure has already been made in reliance on my prior authorization.
If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations. Release of HIV-related information requires additional information.

Signature of Patient or Representative: _____ Date:_____

If not the patient: Relationship to Patient: (Circle one)

Parent Legal Guardian Spouse Other: _____

ESA SOUTH JERSEY BARIATRICS, PA
1103 WEST SHERMAN AVENUE BUILDING 2 UNIT C VINELAND, NEW JERSEY 08360

Date: _____

Dear Patient:

Appointments are in high demand, and your early cancelation will give another patient the possibility to have access to timely medical care.

If you are unable to make your appointment, please be courteous and call at least 24 hours prior to your appointment time to cancel. We have 24 hour answering service that enables you to call and cancel at any time.

If you do not contact our office to cancel this appointment 24 hours prior to your appointment than you will be charged a fee of $50.00.

We do understand that an emergency may occur from time to time, resulting in the need to reschedule an appointment, and we want to remind you of the importance of preventative and follow up care as indicated by your physician.

If you fail to call and cancel your appointment 3 times you will be dismissed from our practice.

I attest that I have been informed of the fee that is involved if I fail to cancel my appointment in the 24 hours prior to my Visit.

Print Name: _____Signature: _____

ESA SOUTH JERSEY BARIATRICS, PA

1103 West Sherman Avenue
Building 2 Unit C
Vineland NJ 08360

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

I authorize the release of information including the claims information, diagnosis, records and examination rendered to me.

O This information may be release to:

Spouse _____ DOB _____/_____/_____

Children _____ DOB _____/_____/_____

Other _____ DOB _____/_____/_____

O Information is not to be release to anyone

Messages

Please call O Home Phone # _____

O Work Phone # _____

O Cell Phone # _____

You may leave detailed message	Yes	No
Please leave a message asking me to return your call	Yes	No

The best time to reach me is (day) _____ between (time) _____

This ***Release of Information*** will remain in effect until terminated by myself in writing

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/___

ESA SOUTH JERSEY BARIATRICS

Name: _____ Date: _____

Current Reason for Today's Visit

What is your reason for seeing the doctor today? _____

What are your current symptoms? _____

_____

How long have you had these symptoms? _____Days _____Weeks _____Months

VACCINATION RECORD

Are you vaccinated for any of the below vaccine, please answer all question and provide vaccine card

Flu Shot? Yes No if yes Where and When: _____

Pneumonia Shot? Yes No if yes Where and When: _____

Covid 19? (circle one) NO Moderna Pfizer Johnson & Johnson's Janssen

Where & Dates: _____

Acid Reflux or GERD

Are you currently having any of the following symptoms of Acid Reflux/GERD? Check below all that apply

Do you experience heartburn or acid reflux more than once a week?	Yes	No
Still suffer from heartburn, after taking over-the-counter or prescription medications?	Yes	No
Have you been taking an OTC medication longer than the product label recommends?	Yes	No
Are your symptoms become more severe over time?	Yes	No
Is your heartburn symptoms lasting longer or become more frequent?	Yes	No
Do you experience severe hoarseness or wheezing?	Yes	No
Has swallowing food or pills becomes difficult or painful?	Yes	No

EMOTIONAL WELL-BEING

Are you currently feeling depressed or anxious? YES NO

If yes, explain how you are feeling? _____

Are you current being treated by a psychiatrist? YES NO

If yes, what is your clinical diagnosis? _____

If yes, are you taking any medication? YES NO

If yes, what medication are you taking? _____

Do you feel like you want to harm yourself? YES NO

If yes please explain so we can get you help: _____

ONLY COMPLETE BELOW IF YOU ARE A Bariatric still completing requirements for surgery

How many Nutrition Visits have you completed? 1 2 3 4 5 6

Did you complete your Support Groups? YES NO

Did You Complete the Information Session? YES NO

Have you completed your Psychiatric Evaluation? YES NO

If yes, who did you see? _____ When _____