STUART M. HOMER MD
& ASSOCIATES

HYPERTENSION • NEPHROLOGY • INTERNAL MEDICINE

We would like to take this opportunity to welcome you and to say thank you for choosing our office for your medical needs.

To ensure that your visit runs as smoothly as possible, please have the following documentation with you:

- Current Health Insurance Card
- Referral Form from Primary Physician if Applicable
- One Form of Identification (driver's license, social security card, etc.)
- Recent Blood Work and/or Laboratory Results
- Recent Diagnostic Test Results (x-rays, scans, ultrasounds etc.)
- Current Medications In Their Original Bottles.

In addition there are other forms, which, if you fill out in advance, will further expedite your visit and provide our health care practitioners the information they need to provide you with the best care possible. These are available on our website. Thank you in advance for your cooperation. If you have any questions or desire further information, please feel free to contact our office at 732-602-0244. We look forward to meeting you.

Sincerely,

Stuart M. Homer, MD, FACP
Geraldine Dolan, APN
Daniyel Barton, APN
and Staff

PLEASE USE BLACK INK **APPT DATE:** _____

1030 St. Georges Avenue • Suite 201 • Avenel, NJ 07001 • Office (732) 602-0244 • Fax (732) 602-2577 • www.kidneydoctornj.com

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PATIENT REGISTRATION

PATIENT NAME: *Last* _____ *First* _____ *MI* _____

ADDRESS: *Street* _____ *City* _____ *ST* _____ *Zip* _____

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____

May we leave a message on home phone: Yes No May we leave a message on cell phone: Yes No

PERSONAL E-MAIL*: _____

** By providing an email address you will automatically be web enabled and enrolled in our practice patient portal.*

MARITAL STATUS: Single Married Divorced Separated Widowed

SEX: Male Female DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: ( ) _____

Full Name Relation

Who can we thank for referring you to our practice: _____

PATIENT EMPLOYER: _____

EMPLOYER ADDRESS: _____ PHONE NUMBER: ( ) _____

OCCUPATION: _____

EMPLOYMENT STATUS: Full-Time Part-Time Unemployeed Retired

Race**: Asian Black/African American Caucasian Hispanic Other

Ethnicity**: Hispanic/Latino Not Hispanic/Latino

Preferred Language**: English Spanish Other: _____

*** Please note these questions are asked to comply with US Government Requirements.*

PRIMARY INSURANCE: _____

PHONE NUMBER: _____ SUBSCRIBER: _____

ID NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____

PHONE NUMBER: _____ SUBSCRIBER: _____

ID NUMBER: _____ GROUP NUMBER: _____

PRIMARY DOCTOR/REFERRING PHYSICIAN: _____

Please provide Name and City/State

PHARMACY: _____

Please provide Name, Street Address, and State

REASON FOR TODAYS VISIT: Primary Care Specialist

_____

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REVIEW OF SYSTEMS AND UPDATED PATIENT INFORMATION

KINDLY FILL OUT THIS FORM. IT WILL HELP US TO PROVIDE YOU WITH THE BEST CARE.
THIS INFORMATION IS REQUIRED BY YOUR INSURANCE COMPANY AND MEDICARE.

Patient Name: _____ **Date:** _____

CIRCLE ANY SYMPTOMS THAT SHOULD COME TO OUR ATTENTION

GENERAL
FEVER
CHILLS
SWEATS
WEIGHT LOSS/GAIN

GENITO-URINARY
URINARY INFECTION
DIFFICULTY URINATING
EXCESSIVE URINATION
BURNING

ENDOCRINE
EXESSIVE THIRST
EXCESSIVE HUNGER
HEAT/COLD INTOLERANCE
ABNORMAL HAIR GROWTH/LOSS

NEUROLOGIC
WEAKNESS
NUMBNESS
DIFFICULTY MOVING

RESPIRATORY
SHORTNESS OF BREATH
PHLEGM

SKIN
RASH
ITCHING

GASTROINTESTINAL
STOMACH PAIN/BURNING
CONSTIPATION/DIARRHEA
CHANGE IN APPETITE

HEMATOLOGIC
FATIGUE
EASY BRUISING

CARDIAC
CHEST PAIN
PALPITATIONS
BLACK OUT SPELLS

MUSCLE/JOINT
ARTHRITIS
MUSCLE PAIN
JOINT SWELLING

ENT
SINUS PAIN
SORE THROAT
HEARING PROBLEMS

EYES
IMPAIRED VISION
PAIN
DOUBLE VISION

PSYCHIATRIC
ANXIETY
DEPRESSION

NO PROBLEMS

SAME AS LAST VISIT

OTHERS:

INDICATE RECENT VISITS TO ANOTHER DOCTOR IN THE PAST SIX MONTHS:

DR: _____ DATE: _____ PROBLEM: _____
DR: _____ DATE: _____ PROBLEM: _____
DR: _____ DATE: _____ PROBLEM: _____

BEEN HOSPITALIZED: LOCATION: _____ DATES: _____

HAD BLOODWORK: LOCATION: _____ DATES: _____

HAD DIAGNOSTIC TESTING SUCH AS: MRI, ULTRASOUND, X-RAY, ECHO, STRESS TEST, COLONOSCOPY, ETC.

TEST: _____ DATE: _____ LOCATION: _____
TEST: _____ DATE: _____ LOCATION: _____
TEST: _____ DATE: _____ LOCATION: _____

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MEDICAL HISTORY

Patient Name: _____ **Date:** _____

PAST MEDICAL HISTORY

Have you ever had: (Circle)

Diabetes	Kidney Disease	High Triglycerides
Hepatitis	Stones: Location: _____	High Cholesterol
Ulcers	Stroke	Colonic Polyps
Reflux	Voiding Problems	Heart Disease
Lupus	Bladder Infections	High Blood Presure
Arthritis	Peripheral Vascular Disease	Other: _____
Multiple Sclerosis	Prostate Problems	

PAST SURGICAL HISTORY AND PROCEDURES

Please circle and provide dates of surgery or procedure:

Appendectomy	Coronary Artery Bypass
Cataracts	Joint Replacement
Gallbladder	Lithotripsy
Coronary Stents	Prostate Surgery
Hysterectomy	Carotid Surgery
Mammography	Other Vascular Surgery
Colonoscopy	Other: _____

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SOCIAL HISTORY QUESTIONAIRE

Patient Name: _____ **Date:** _____

SOCIAL HISTORY:

Educational Level: (circle) Grade School High School College Post Graduate

Birthplace: _____ **Religion:** *(optional)* _____

Pets: _____ **Marital Status:** _____

Tobacco Use:

Ever use Tobacco? (circle) Yes No

Type of tobacco use: (circle) cigarettes cigars pipe snuff chew vape

Year started smoking: _____ **Year quit smoking:** _____

Number of cigarettes smoked per day: _____

Alcohol Use:

How often did you have a drink containing alcohol in the past year? **Never:** _____

Daily: How many _____ **Weekly:** How many _____ **Monthly:** How many _____

FAMILY HISTORY:

Father's Medical Problems: _____

Still living? Yes No **Age of death:** _____ **Cause of death:** _____

Mother's Medical Problems: _____

Still living? Yes No **Age of death:** _____ **Cause of death:** _____

Siblings Medical Problems:

Brother/Sister: _____

Brother/Sister: _____

Brother/Sister: _____

Brother/Sister: _____

Brother/Sister: _____

Do you have any blood relatives with the following medical problems?

Kidney Disease	Diabetes	Blood Clots
Bladder Problems	Heart Disease	Rheumatoid Arthritis
Prostate Problems	Stroke	Emphysema/COPD
High Blood Pressure	Connective Tissues Disease	Cancer
Asthma	Sleep Apnea	

OCCUPATIONAL HISTORY:

Occupation: Current: _____

Previous: _____

Have you ever had occupation exposure to any of the following?

Asbestos Chemical Dust Metal Dust Gas Fumes Lead Other: _____

Describe length and type of exposure: _____

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Medication Record

Name: _____

Date	Medication	Dose Given	Frequency (i.e. 2x per day)	Time	am / pm

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Release of Records

I, _____ authorize physicians, specialist and facilities who hold my medical records to release to **STUART M. HOMER, MD** at **1030 ST GEORGES AVE, SUITE 201, AVENEL, NJ, 07001** copies of my medical records. I understand this release includes primary care physicians, specialist, medical and diagnostic facilities. I further authorize the release of my insurance carrier and policy numbers to Stuart M. Homer MD and Associates. I recognize that the sharing of this confidential information is necessary to facilitate my medical care.

Signed: _____ **Todays Date:** _____

Date of Birth: _____

Consent for RX Hub Inquiry

I hereby provide my consent for the practice of Stuart M. Homer MD & Associates to obtain my RX history using SureScripts-RxHub network. I understand that this inquiry will provide my physician with the accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-RxHub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All quires and responses are made automatically through secure system-to-system communications.

Signed: _____ **Todays Date:** _____

Designation of Disclosure and Privacy Practices (HIPAA)

I agree that my Protected Health Information (PHI) may be shared with the following people:

1: _____ **2:** _____

We are required by law to maintain the privacy and security of your protected health information (PHI). We are also required to provide you with our notice of privacy practices which describes our legal responsibilities and your rights regarding the use and disclosure of your PHI. Your signature below is an acknowledgement that you have received our notice of privacy practices. (Please ask for your copy.)

Signed: _____ **Todays Date:** _____

Assignment of Benefits

I authorize; 1. The use of this form, whether original or copy to be used on my insurance and/or Medicare; 2. Release of information to all my insurance companies including; 3. Payment directly to Stuart M Homer MD & Associates from Medicare, all insurance companies, and/or third party payers; 4. MD to act as my agent in helping me obtain payment from my insurance company and/or Medicare. I understand that I am responsible for my bill. I request that payment of authorized Medicare benefits be made on my behalf to MD. I give permission to MD to fill out the Medicare forms on my behalf.

PrintName: _____ **Todays Date:** _____

Signature: _____

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Financial Policy

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete our Patient Information Sheets before seeing the doctor.

Unless previous arrangements have been made, all payments are due at the time of the appointment. Payment may be made by **CASH, CHECK, VISA OR MASTERCARD**. We only bill insurance carriers with whom we participate (have signed an agreement with).

Regarding Managed Care Insurance with which we participate:
You are responsible to supply our staff with your primary and secondary insurance identification cards(s) at the time of your appointment. If your insurance company requires a referral from your primary doctor, you must also present this to our receptionist prior to being seen, as we cannot bill your insurance without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the visit in full. If your insurance requires a copay, it must be paid **at the time** of the appointment.

Regarding Non-Participating Insurances:
If we do not participate with your insurance, the bill is your responsibility and is due at the time of service. We accept CASH, CHECK, MASTERCARD and VISA. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

Medicare:
We do participate with Medicare. This means that we will submit your claim to Medicare. The 20% difference between what Medicare "allows" and what Medicare "pays" will be sent to your secondary insurance if you have one, or to you. You will also be responsible for your yearly Medicare Part B deductable.

Return Check Fee - $30:
Our bank charges us a fee for any check that is returned for "insufficient funds" and this will be added to the patient's bill if this occurs.

If you are unable to keep a scheduled appointment, 24 hours notice of cancellation is required. Otherwise a $75 charge will be made for the time that was reserved to you.

Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process. **Accounts that go to collection will be subject to a 25% charge.**

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns, please feel free to ask. If you cannot pay in full at the time of service, please let us know before you see the doctor. We are happy to work out a payment plan.

I have read the above Stuart M. Homer MD & Associates Financial Policy. I understand and agree to abide by its terms.

Name: _____
(Please Print)

Signed: _____ **Date:** _____

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