



**PATIENT REGISTRATION**  
Please print ALL information.

**PATIENT INFORMATION**

Patient last name: \_\_\_\_\_ Patient first name: \_\_\_\_\_  
Street address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_  
Emergency phone: ( ) \_\_\_\_\_ Contact person: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_ Employment status: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Gender (circle): Male Female Smoker (circle): Yes No

**REFERRING PHYSICIAN INFORMATION (Who referred you to the Neuroscience Institute?)**

Referring Physician: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Office phone number: ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

**PRIMARY CARE PHYSICIAN INFORMATION**

Primary Care Physician: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Office phone number: ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

**OTHER PHYSICIAN(S) YOU WISH TO RECEIVE Neuroscience Institute REPORTS**

Referring Physician: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Office phone number: ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

**PHARMACY INFORMATION**

Pharmacy: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone number: ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance name: \_\_\_\_\_  
Insurance street address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Ins. phone: (     ) \_\_\_\_\_ Insurance ID number: \_\_\_\_\_  
Group name (employer): \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured person: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Insured street address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance name: \_\_\_\_\_  
Insurance street address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Ins. phone: (     ) \_\_\_\_\_ Insurance ID number: \_\_\_\_\_  
Group name (employer): \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured person: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Insured street address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

How did you learn of our practice?

**Please Bring Your Insurance Cards – (we require copies)**

**Please Bring Charity Care Letter – (if applicable)**

**Please Bring Motor Vehicle or Workmen Compensation Information  
(if applicable)**

**Please Bring All FILMS from Outside Facilities – Old and New (X-rays,  
CT, MRI, etc.) relevant to your Condition.  
(JFK and Edison Imaging Films will be requested by our Staff and will be pulled for your visit)**

**AND REPORTS (you will need to request reports)**



# GENERAL CONSENT

Patient name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Account Number: \_\_\_\_\_  
Attending Physician: \_\_\_\_\_

## TREATMENT CONSENT

I have a condition requiring medical care. I hereby consent and authorize the administration of all routine Hospital care which may include, but is not limited to, performance of all examinations, administration of medications, administrations of drugs, including the administration and use of anesthesia or anesthetics, infusions, plasma or blood transfusions, injections, emergency, outpatient, inpatient and diagnostic treatments, services and procedures, and such other medical treatments as my doctors, or other health care practitioners caring for me deem appropriate.

Hospital but, rather, are members of its Medical/Dental staff who have been granted the privilege of using its facilities for the care and treatment of their patients. Similarly, EDISON RADIOLOGY GROUP, PA., JAMES STREET ANESTHESIA ASSOCIATES, P.A., CENTRAL JERSEY PATHOLOGY CONSULTANTS, P.A., MID-STATE RADIATION ONCOLOGY ASSOCIATES, P.A., EDISON IMAGING ASSOCIATES, P.A., MIDDLESEX EMERGENCY ASSOCIATES, are not agents or employees of the Hospital, but rather are independent contractors who have been granted a contract to provide services and have been granted privileges to use its facility for the care and treatment of their patients. Further, among those who may care and treat me and/or be present during my care and treatment may include medical, nursing, and other health care personnel in training such as interns, residents and student nurses and vendors and other individuals deemed appropriate by the Hospital or by doctors; and

### In giving consent, it is my understanding that:

- i. the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risk of injury or even death, and I acknowledge that no guarantees have been made to me as to the result of any examinations or treatments provided;
- ii. many of the physicians on the staff of the Hospital, including my attending physician, may not be employees or agents of the

- iii. I have the right to consent, or otherwise refuse consent, to any proposed treatment procedure or therapeutic course.

## PATIENT VALUABLES

I understand that the Hospital shall not be responsible for any of my personal property, which is not deposited in Hospital vaults. I further understand that the Hospital shall not be responsible for any artificial devices including, but not limited to eyeglasses, contact lenses, hearing aids and dentures which are retained in my possession while at the Hospital.

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices, which provides a description of how my protected health information may be used or disclosed.

## SIGNATURES

I have read this form (or have had it read to me) and have had all my questions answered. I am satisfied that I understand the significance of its content and agree to its terms.

Signature ( Patient ): \_\_\_\_\_ Date: \_\_\_\_\_

Signature ( Witness ): \_\_\_\_\_ Date: \_\_\_\_\_

If patient is unable to consent or is a minor complete the following:

Patient is: \_\_\_\_\_ a minor of \_\_\_\_\_ years of age.

Patient is: \_\_\_\_\_ unable to consent because \_\_\_\_\_

I hereby certify that I am the legally authorized representative of the patient who is entitled to make decisions on his/her behalf.

Signature ( Personal Representative ): \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative's Name (Print): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

If interpreter used:

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

If verbal/telephone consent obtained:

Signature ( Employee ): \_\_\_\_\_ Date: \_\_\_\_\_

Signature ( Witness ): \_\_\_\_\_ Date: \_\_\_\_\_

## N.J. HOSPITAL CARE PAYMENT ASSISTANCE PROGRAM

The undersigned hereby acknowledges receipt of the availability of N.J. Hospital Care Payment Assistance Program as mandated by the New Jersey State Department of Health and Senior Services.

Signed: \_\_\_\_\_

Relationship: \_\_\_\_\_

Hospital Representative: \_\_\_\_\_

Date: \_\_\_\_\_

K006 Rev. 04/03





BILLING CONSENT

Patient name: \_\_\_\_\_
Date of Birth: \_\_\_\_\_

Account Number: \_\_\_\_\_
Attending Physician: \_\_\_\_\_

MEDICARE PATIENT'S CERTIFICATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security or its intermediaries or carriers all information needed for this or a related medical claim. I request that payment of authorized benefits be made on my behalf. I assign to JFK Medical Center the benefits payable for the services rendered at this Hospital for me.

ASSIGNMENT OF BENEFITS

I hereby promise to pay to the order of JFK Medical Center, Radiologists, Anesthesiologists, Pathologists, Oncologists and Emergency Department Physicians (the "PROVIDERS") charges in consideration for the services rendered and to be rendered by the Providers. I (we) understand that all bills are due and payable promptly after presentation, and both the patient and all other signatories of this agreement are jointly and severally responsible for all charges. I (we) further agree that if the payment in full of the Providers charges is not made and if the Providers bill(s) are referred to a third party for collection, I (we) shall be responsible for and shall pay reasonable attorneys' fees and collection expenses. I (we) further agree that if the patient is entitled to JFK Medical Center and/or physician benefits from any insurance policy or any benefit plan of an employer or other third party payor ("Insurance Benefits"), I (we) assign the Insurance Benefits directly to the Providers for application to the Providers bill(s). Any delay in payment of Insurance Benefits to the Providers will not alter or postpone responsibility of the undersigned for payment. Failure to insist upon payment while the Providers await payment of Insurance Benefits shall not be construed as a waiver by the Providers of my (our) responsibility.

RELEASE OF INFORMATION TO THOSE FINANCIALLY LIABLE

I authorize JFK to release any and all information (INCLUDING GENETIC, HIV, DRUG AND ALCOHOL, AND MENTAL HEALTH RELATED INFORMATION) to other facilities for discharge planning purposes and/or to government agencies, insurance carriers, employers or others who are financially liable for my medical care and treatment and/or their representatives or agents to effect payment. I understand that in giving this consent, I am waiving my legal right to confidentiality of all information including those specifically applicable to GENETIC, HIV, DRUG AND ALCOHOL, AND MENTAL HEALTH RELATED INFORMATION. I also understand that if I do not consent to the release of this information for discharge planning purposes and/or to those financially responsible for payment of my bill, I will become personally responsible for payment of any medical bills incurred as a result of this refusal.

SIGNATURES

I have read this form (or have had it read to me) and have had all my questions answered. I am satisfied that I understand the significance of its content and agree to its terms.

Signature ( Patient ): \_\_\_\_\_ Date: \_\_\_\_\_

Signature ( Witness ): \_\_\_\_\_ Date: \_\_\_\_\_

If patient is unable to consent or is a minor complete the following:

Patient is: \_\_\_\_\_ a minor of \_\_\_\_\_ years of age.

Patient is: \_\_\_\_\_ unable to consent because \_\_\_\_\_

I hereby certify that I am the legally authorized representative of the patient who is entitled to make decisions on his/her behalf.

Signature ( Personal Representative ): \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative's Name (Print) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

If interpreter used:

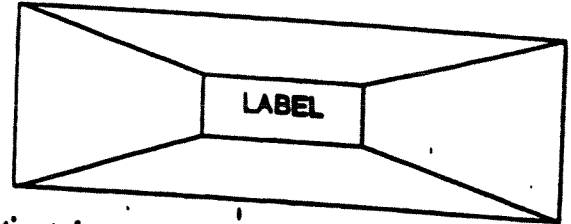
Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

If verbal/telephone consent obtained:

Signature ( Employee ): \_\_\_\_\_ Date: \_\_\_\_\_

Signature ( Witness ): \_\_\_\_\_ Date: \_\_\_\_\_



**COMMUNICATION ASSESSMENT TOOL**

In order to assure that the services that are provided to you (or the patient that you are legally responsible for) are not compromised by ineffective communication there are several tools which may assist you. TDDs (Telecommunications Devices for the Deaf), CyraPhones, amplified telephones, information in large print, etc. can be provided at no cost to you. Please assist us by completing this form so that our health care providers will be aware of your communication needs. Kindly check each applicable item.

**DEAF/HARD OF HEARING**

- I require the use of a TDD \*
- I require the use of closed captioning for the television \*
- I prefer to lip-read and speak for myself for brief communications
- I prefer to lip-read and speak for myself for all communications
- I require a qualified sign language interpreter for communications with my physician & hospital staff. + #
- OTHER (Please Specify) \_\_\_\_\_
- I require the use of an amplified telephone \*
- I prefer written notes for brief communications
- I prefer written notes for all communications

**VISUALLY IMPAIRED / BLIND**

- I require assistance with printed materials.

**LIMITED ENGLISH PROFICIENCY**

When appropriate any of the individual (s) listed below may serve as my interpreter for communication with my physician (s) and hospital staff. Use of the CyraPhone as outlined below is encouraged. #

Specify Language: \_\_\_\_\_

**INTERPRETER NAME**

**AREA CODE - PHONE NUMBER**

I understand that an interpreter will gain knowledge of my confidential medical information during interpretive services. I consent to the use of an interpreter.

I have read this form (or had it read to me) and had all my questions answered. I am satisfied that I understand the significance of its content and agree to its terms.

Signature (Patient/Proxy): \_\_\_\_\_ Date: \_\_\_\_\_

Signature (Witness) \_\_\_\_\_ Date: \_\_\_\_\_

Proxy's Name (Print): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Reason patient unable to complete (if applicable): \_\_\_\_\_

If interpreter used: Name (Print) \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

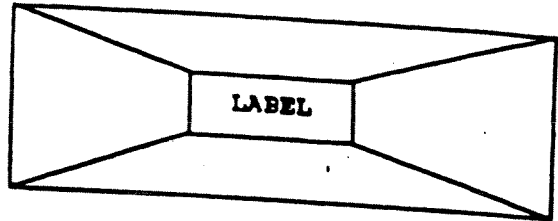
- Contact Communications by dialing \*0\*.
- + Contact the Patient Representative Department at x 67566 to arrange for a qualified interpreter. When the office is closed, call the Operator for a list of qualified interpreters. In an emergency, call the ASL Referral Service at 1-800-273-7391.
- # Where a qualified interpreter is the preferred method of communication, that individual or CyraPhone service should be used in all situations where effective communication is necessary to ensure that the patient is receiving equal services and opportunity to participate in and benefit from hospital services. These situations include, but are not limited to obtaining medical history, obtaining consent, diagnosis of illness, emergency situations, explanation of medications, etc.

**THIS IS A PERMANENT PART OF THE MEDICAL RECORD**





**JFK** JFK Medical Center



**ADVANCE DIRECTIVE / PATIENT RIGHTS INFORMATION FORM**

Sections I, II, III to be completed by Registrar

**I. Advance Directive  Yes**

**Decision maker/Proxy/Power of Attorney for Health Care Decisions**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Copy (Not Original) attached     Copy on file in medical record     Copy requested from:

Patient     Other (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_

**II. Advance Directive  No  Unable to determine Advance Directive status**

Advance Directive document provided.

Referral to Patient Representative Department for questions or assistance in preparing Directive (732-321-7566 or 67566 from a patient room).

Advance Directive document refused.

**III. Please check:**

"Your Right to Make Health Care Decisions in New Jersey" and "Your Rights As A Patient" provided.

Patient is unable to receive information. \*

**\*NOTE: SHOULD THE PATIENT REGAIN THE ABILITY TO MAKE HIS/HER OWN DECISIONS, INFORMATION MUST BE PROVIDED TO PATIENT.**



**The New Jersey Neuroscience Institute**  
**Medical Review of Systems** (revised 3/07)

Name \_\_\_\_\_ Date \_\_\_\_\_

**Who referred you to the New Jersey Neuroscience Institute?**

Name of Referring Physician

\_\_\_\_\_

Do you consider yourself at risk for falling? Yes \_\_\_\_\_ No \_\_\_\_\_

**Please describe your problem to us and tell us when your problem started:**

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**The next few pages will ask questions about your type of pain, past medical history, past surgical history, family history, social history, symptoms you may be having (review of systems) and medications. If you need additional space for some of your answers, use the space below.**

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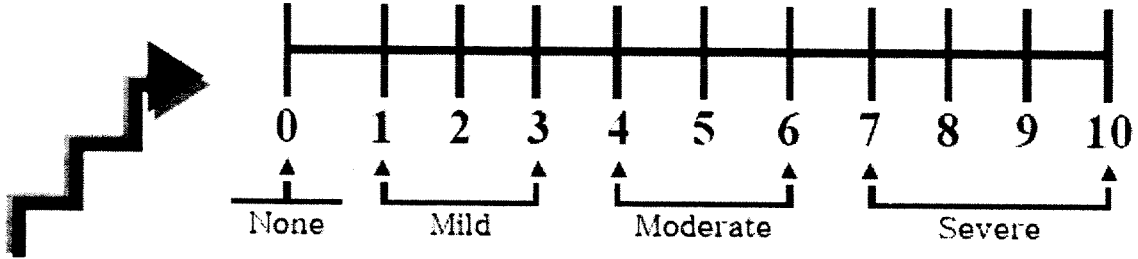
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# The New Jersey Neuroscience Institute

Medical Review of Systems (revised 3/07)

Do you have pain? \_\_\_\_\_

Use this scale to describe your pain:



What number would you give your pain right now? \_\_\_\_\_

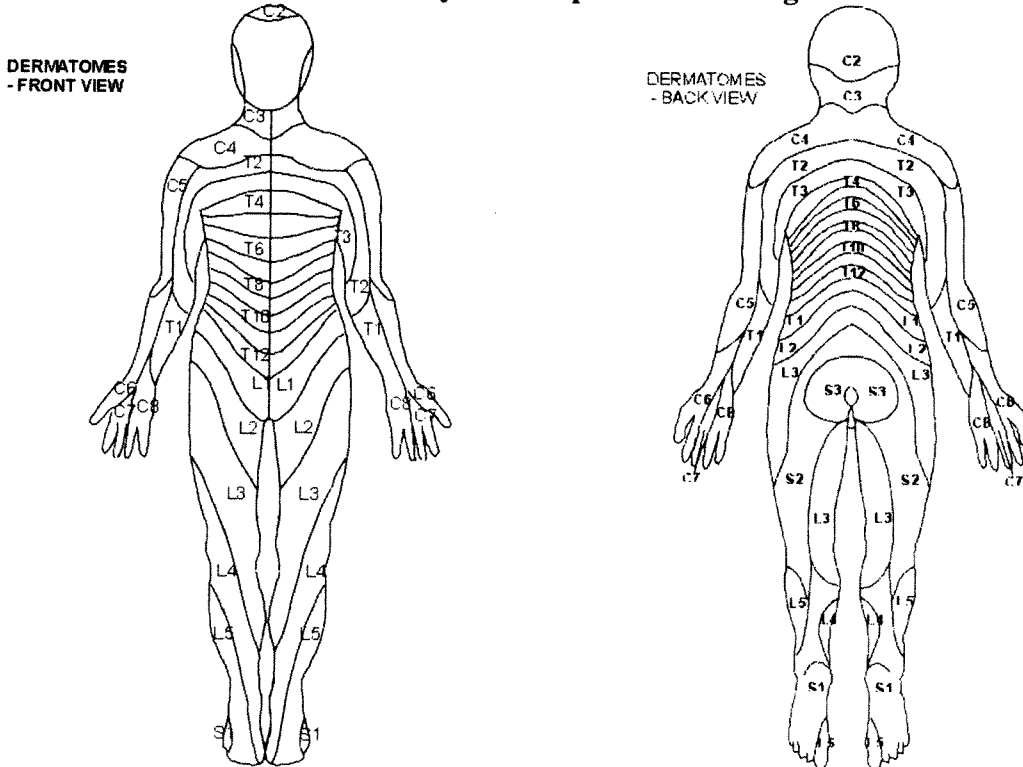
What number on a 0 to 10 scale would you give your pain when it is the worst that it gets and when it is the best that it gets?

Worst \_\_\_\_\_ Best \_\_\_\_\_

How much pain do you usually have? \_\_\_\_\_

At what number is the pain at an acceptable level for you? \_\_\_\_\_

Please indicate the areas where you have pain on this diagram:



MD initial and Date \_\_\_\_\_

# The New Jersey Neuroscience Institute

## Medical Review of Systems (revised 3/07)

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

### PAST MEDICAL HISTORY (Please circle if applicable)

<b>Cardiac</b>	Heart Attack	Pacemaker	Abnormal Rhythm	Other: _____
<b>Circulatory</b>	Hypertension	Stroke	Aneurysm	Other: _____
<b>Endocrine</b>	Diabetes	Thyroid	High cholesterol	Other: _____
<b>Neurologic</b>	Seizures	Migraines	Head Injury	Other: _____
<b>Pulmonary</b>	COPD	Asthma	Emphysema	Other: _____
<b>Gastro/Renal</b>	Ulcer	Kidney disease	Enlarged prostate	Other: _____
<b>Infectious</b>	Tuberculosis	Lyme's	HIV/AIDS	Other: _____
<b>Ophthalmic</b>	Glaucoma	Retinal disease	Cataract	Other: _____
<b>Skeletal</b>	Joint replacement	Arthritis		Other: _____
<b>Gynecologic</b>	Pregnancies _____	Miscarriages _____		Other: _____
	Pregnancy complications _____			
<b>Cancer</b>	Type _____			
<b>Other:</b>	_____			

### PAST SURGICAL HISTORY (Please list type, date, and surgeon/hospital)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### FAMILY HISTORY (Please circle & list parent/sibling with illness/age of death)

Heart Attack Hypertension Diabetes Stroke Dementia Aneurysm Migraine  
Brain tumor Breast Cancer Colon Cancer Other \_\_\_\_\_  
Mother \_\_\_\_\_ Father \_\_\_\_\_  
Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ Others \_\_\_\_\_

### SOCIAL HISTORY

Occupation: \_\_\_\_\_ Highest education completed \_\_\_\_\_  
Disabled \_\_\_\_\_ Last worked \_\_\_\_\_  
Do you smoke cigarettes? \_\_\_\_\_ If so, how much \_\_\_\_\_ Former smoker \_\_\_\_\_  
Recreational drugs (list) \_\_\_\_\_ Type of Alcohol \_\_\_\_\_  
Alcohol Use: Never \_\_\_ Occasionally \_\_\_ Monthly \_\_\_ Weekly \_\_\_ Daily \_\_\_

### REVIEW OF SYSTEMS (Please circle)

<b>Neurologic</b>	Headache	Dizziness	Memory loss	Numbness	Other _____
<b>Eyes</b>	Glasses	Contacts	Blurriness	Double Vision	Other _____
<b>Ears/Throat</b>	Deafness	ringing	Swallowing	Hoarseness	Other _____
<b>Cardiac</b>	Chest Pain	Abnormal Beats	Loss of Consciousness		Other _____
<b>Pulmonary</b>	Cough/Cough	Blood	Wheezing	Shortness of Breath	Other _____
<b>Intestinal</b>	Constipation	Diarrhea	Incontinence	Bleeding	Other _____
<b>Urinary</b>	Frequency	Burning	Incontinence	Bleeding	Other _____
<b>Muscle/Bone</b>	Pain	Weakness	Cane/Walker		Other _____
<b>Endocrine</b>	unexplained	Weight Gain/Weight Loss		Fatigability	Other _____
<b>Skin</b>	Bruising	Lesions	Birth Marks		Other _____
<b>Hematologic</b>	Bleeding	Transfusion	Blood clots	Anemia	Other _____
<b>Psychiatric</b>	Depression	Addiction	Anxiety		Other _____
<b>Sleep</b>	Gasping for Breath	Stop Breathing		Insomnia	Other _____

**The New Jersey Neuroscience Institute**  
**Medical Review of Systems (revised 3/07)**

**OTHER INFORMATION**

How do you prefer to learn?  
 Written material?

Verbal directions?

Do you have a need to discuss any emotional, or physical harm that you may be experiencing?  YES  NO

Have you ever thought about hurting yourself?  YES  NO

If yes, have you ever acted upon these thoughts?  YES  NO

Are you thinking of suicide now?  YES  NO

**RELIGION**

Do you have any religious, or cultural needs related to your care?  
(i.e., diet, blood transfusion, or religious practices)

YES

NO

If yes, Comments:

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MD Initial and Date: \_\_\_\_\_

