Patient Name: _____ Date of Birth:_____ Today's Date: _____
First Middle Initial Last

NEW JERSEY CANCER CARE, PA

_____ Belleville Office _____ Montclair Office _____ Roselle Office _____ Oceanport Office

___ Dr. Bondili ___Dr. Conti ___Dr. Najib ___ Dr. Orsini Sr. ___ Dr. Orsini Jr. ___ Dr. Saleh ___ Dr. Vasireddy ___ Dr. Yerramalli

PATIENT INFORMATION

Please Print Clearly & Fill Out Completely

Last Name	First Name	Middle Initial
Date of Birth	Age	Social Security Number
Address	Primary Doctor	Referring Doctor
City	State / Zip	Email
Home Phone ( ) -	Cell Phone ( ) -	Work Phone ( ) -

PRIMARY INSURANCE COVERAGE

Insurance Company Name	Insurance Care is in the Name of? ❑ Self ❑ Spouse ❑ Other

Complete the following information for the person whose name appears on the Insurance Card:

Name	Date of Birth	Social Security Number
Group #	Plan Name	
Policy ID #	Medical Group Name	Co-Pay $

Does your insurance require a referral to see a specialist? ❑ NO ❑ YES (If YES, please give referral slip to receptionist)

SECONDARY INSURANCE COVERAGE

Insurance Company Name	Insurance Care is in the name of? ❑ Self ❑ Spouse ❑ Other

Complete the following information for the person whose name appears on the insurance card:

Name	Date of Birth	Social Security Number
Group #	Plan Name	
Policy ID #	Medical Group Name	Co-Pay $

Does your insurance require a referral to see a specialist? ❑ NO ❑ YES (If YES, please give referral slip to receptionist)

Emergency Contact

Name	Relationship	Phone

PATIENT DEMOGRAPHICS

RACE / ETHNICITY

- ❑ Decline to Answer
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian / Pacific Islander
- ❑ White / Caucasian
- ❑ Other
- ❑ Unknown
- ❑ Asked but unknow

GENDER **AT BIRTH**

❑ Male ❑Female

GENDER IDENTITY

- ❑ Male ❑ Female
- ❑ Female-to-male(FTM)Transgender Male/Trans Man
- ❑ Male-to-Female(MTF)Transgender Female/Trans Woman
- ❑ Genderqueer, neither exclusively male nor female
- ❑ Additional gender category or other, please specifiy _____
- ❑ Decline to answer

PREFERRED LANGUAGE

- ❑ Decline to Answer
- ❑ English
- ❑ Spanish
- ❑ French
- ❑ Punjabi
- ❑ Hindi
- ❑ Sign Language - Deaf
- ❑ Vietnamese
- ❑ Chinese
- ❑ Russian
- ❑ Tagalog
- ❑ Italian
- ❑ Other
- ❑ Visually Impared

Sexual Orientation

- ❑ Lesbian, gay, or homosexual
- ❑ Straight or heterosexual
- ❑ Bisexual
- ❑ Something else please describe _____
- ❑ Don't Know
- ❑ Decline to answer

MARITAL STATUS

- ❑ Decline to Answer
- ❑ Divorced
- ❑ Domestic Partner
- ❑ Other
- ❑ Single
- ❑ Married
- ❑ Widow

EMPLOYER

Current Employer: _____

Address:

_____

_____

Telephone: _____

Retired: ❑ Disabled: ❑

Patient Name: _____ Date of Birth:_____ Today's Date: _____
First Middle Initial Last

PAST MEDICAL HISTORY			
Do you have or have you had any of the following conditions?	**YES**	**NO**	**Type / Year Diagnosed**
Cancer	❑	❑	
Heart Disease	❑	❑	
Have you had an EKG?	❑	❑	When/Where?
High Blood Pressure	❑	❑	
Pacemaker	❑	❑	
Reflux or Stomach Ulcers	❑	❑	
Diabetes	❑	❑	
Arthritis	❑	❑	
Stroke	❑	❑	
Lung Disease (Asthma, Emphysema, Pneumonia)	❑	❑	
Prostate Disease	❑	❑	
Bladder Disease	❑	❑	
Seizures	❑	❑	
Mental Illness (Nervous condition/Depression)	❑	❑	
Any other illnesses?	❑	❑	
Have you had any accidents/injuries within the last 24 months?	❑	❑	
Have you ever received the Shingles Vaccine?	❑	❑	
Have you received the COVID vaccine?	❑	❑	

PAST SURGICAL HISTORY	
Type of Operation	Date(s)

CANCER TREATMENT HISTORY				
	YES	**NO**	**Area of Body**	**Facility / City**
Have you ever had radiation or x-ray treatments?	❑	❑		
Have you ever had chemotherapy?	❑	❑		
Did you have any adverse reactions to treatment?	❑	❑	If Yes, describe:	
Have you ever participated in a Clinical Trial?	❑	❑		
Would you like information on Clinical Trials?	❑	❑		
Names of All Physicians & Office Locations/Addresses:				

Advanced Directives		
Living Will: Yes No	**DNR: Yes No**	**Durable Power of Attorney: Yes No**

Patient Name: ____ Date of Birth:_____________ Today's Date: _____________
First *Middle Initial* *Last*

FAMILY HISTORY

RELATION	AGE(S)	STATE OF HEALTH	IF DECEASED, CAUSE/AGE OF DEATH
Mother			
Father			
Siblings			
Spouse			
Children			
Are you of Ashkenazi Jewish descent?	**YES**	**NO**	

SOCIAL HISTORY

(✓)	SUBSTANCE:	APPROXIMATE YEAR STARTED / FREQUENCY:
❑	ALCOHOL	Year: ☐ Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always
❑	SMOKING STATUS	❑ Current/Every Day ❑ Current/Some Days ❑ Former Smoker ❑ Never Smoker ❑ Unknown
❑	TOBACCO	Year: Pack(s) A Day: Quit: ☐ NO ☐ YES *If YES*, Date Quit:
❑	STREET DRUGS/OTHER	Year: Type:

ALLERGIES

☐ No Known Allergies ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Other (List All):

Describe Reaction(s):

CURRENT MEDICATION LIST

DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

Patient Name: _____ Date of Birth:_____ Today's Date: _____
First Middle Initial Last

Review of Systems

CONSTITUTIONAL	YES	NO
Weight loss in past year	❑	❑
Fever in the last month	❑	❑
Night sweats	❑	❑
Fatigue	❑	❑
Appetite change	❑	❑
EYES,EARS,NOSE,THROAT	**YES**	**NO**
Blurred or double vision	❑	❑
Nose bleeds	❑	❑
Hearing loss	❑	❑
Mouth sores	❑	❑
Sore thorats	❑	❑
Hoarseness	❑	❑
Trouble swallowing	❑	❑
Sinus problems	❑	❑
RESPIRATORY	**YES**	**NO**
Shortness of breath	❑	❑
Cough	❑	❑
Coughing up blood	❑	❑
Bronchitis	❑	❑
Pneumonia	❑	❑
Emphysema or COPD	❑	❑
Asthma	❑	❑
Blood clots to lung	❑	❑
Flu Shot Date last received:	❑	❑
Pneumonia shot Date last received:	❑	❑
Covid-19 Shot Last shot date: _____ Boosted?:	❑ ❑	❑ ❑
Cardiovascular	**YES**	**NO**
Chest pain	❑	❑
Palpitations	❑	❑
Swelling in feet or legs	❑	❑
High Blood Pressure	❑	❑
Heart valve disease	❑	❑
Heart murmurs	❑	❑
Coronary artery disease	❑	❑
High cholesterol	❑	❑
Previous heart attack	❑	❑
Congestive heart failure	❑	❑
Irregular heart beat	❑	❑
Blood clots to leg/arm	❑	❑

SKIN	YES	NO
Rash / itchiness	❑	❑
Jaundice	❑	❑
GASTROINTESTINAL	**YES**	**NO**
Nausea / vomiting	❑	❑
Abdominal pain	❑	❑
Liver disease / hepatitis	❑	❑
Peptic ulcers	❑	❑
Diarrhea	❑	❑
Rectal bleeding	❑	❑
Constipation	❑	❑
Colonoscopy Date last performed:	❑	❑
Sigmoidoscopy Date last performed:	❑	❑
Endoscopy Date last performed:	❑	❑
Cologuard	❑	❑
HEMATOLOGIC	**YES**	**NO**
Anemia	❑	❑
Low platelet counts	❑	❑
Enlarged lymph glands	❑	❑
Abnormal bleeding	❑	❑
Familial thalassemia	❑	❑
Excess bruising	❑	❑
ENDOCRINE	❑	❑
Diabetes	❑	❑
Thyroid disease	❑	❑
NEUROLOGICAL	**YES**	**NO**
Headaches	❑	❑
Dizziness	❑	❑
Fainting	❑	❑
Seizures	❑	❑
Diffulty walking	❑	❑
Numbness feet / hands	❑	❑
Stroke	❑	❑
PSYCHOSOCIAL	**YES**	**NO**
Depression	❑	❑
Anxiety	❑	❑
Isomnia	❑	❑
Mental illness	❑	❑
Drug Abuse	❑	❑
Alcohol abuse	❑	❑

MUSCULOSKELETAL	YES	NO
Artritis	❑	❑
Osteoporosis	❑	❑
Joint Pain	❑	❑
New bone pain	❑	❑
Fractures (in past 2 years)	❑	❑
GENITOURINARY	**YES**	**NO**
Pain with urination	❑	❑
Blood seen in urine	❑	❑
Bladder infections	❑	❑
Kidney infections/stones	❑	❑
Kidney disease	❑	❑
MALES ONLY	❑	❑
Incontinence	❑	❑
Slow stream	❑	❑
Dribbling	❑	❑
Erectile Dysfunction	❑	❑
Prostate / Rectal Exam	❑	❑
Date last performed:		
PSA drawn	❑	❑
1st Result:		
Most recent result:		
FEMALES ONLY		
GYNECOLOGICAL	**YES**	**NO**
Fibrocystic ovaries	❑	❑
Fibrocystic breasts	❑	❑
Date of last mammogram:		
Any breast biopsies in past	❑	❑
Date of last pap/pevlic exam:		
Currently pregnant	❑	❑
Desire for fertility	❑	❑
# of pregnances	❑	❑
# of children		
# of spontaneous abortion / miscarriage		
# of therapeutic abortions		
Breast Feed	❑	❑
Age at first live birth		
Age menstrual periods began		
Date of last menstrual period		
Menstrual cycle length		
Menopause status	Pre ❑ Post ❑ Peri ❑	
Taking hormonal therapy	❑	❑
Taking birth control past or present	❑	❑

Anything else you would the doctor to know?

Patient Name: _____ Date of Birth:_____ Today's Date: _____
First Middle Initial Last

CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to New Jersey Cancer Care, PA to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct.

*** **SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

PREFERRED OUTSIDE PHARMACY

New Jersey Cancer Care, PA has an Onsite Physician Dispensing Pharmacy for your convenience. Our service is particularly helpful for new prescriptions and refills given to you while you're here in the office. In addition to our most frequently prescribed medications, we focus on stocking medications that have been difficult for our patients to acquire. The co-pay costs are no different than they would be in your local pharmacy. Our staff will do everything possible to help lower your co-pay and will also provide support and information on medication assistance programs. There is no obligation to have prescriptions filled at New Jersey Cancer Care, PA. You may continue to receive your medications at the pharmacy of your choice.

Name, Address & phone number of current Pharmacy: **Is this is a MAIL ORDER PHARMACY? ❑ Yes ❑ No**

PATIENT INFORMATION AUTHORIZATION – HIPAA PRIVACY

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Completion of this form tells us your preferences with regard to telephone messages and whom you give authorization for our office to speak with on your behalf. Further authorization may be needed under more specific circumstances.

CONTACT PREFERENCE *(Check ONE):* ❑ HOME ❑ CELL ❑ WORK ❑ **E**MAIL

❑ Leave message with call-back number only **Number:** ( ) -	❑ **EMAIL:**

***** *Either with any individual, other than yourself, whom answers the phone or on an answering machine.*

OTHER AUTHORIZED INDIVIDUALS

Other individuals I authorize to take messages or receive my Protected Health Information are:

NAME *(List all that apply)*	**RELATIONSHIP TO YOU**	**CONTACT INFO**
		Phone: ( ) -
		Phone: ( ) -

My signature below authorizes **New Jersey Cancer Care, PA** to use my Protected Health Information per my instructions above and acknowledges that I have received **New Jersey Cancer Care, PA** Notice of Privacy Practices & I consent to the use and disclosure of my health information for treatment, payment or healthcare operations.

*** **SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient
Witness Name / Signature	Date

My signature below indicates that I have read, understood and agreed **to the following:**
Patient payment, Finanical, Authorization and Release to be photographed for EMR, Patient Education and Administrative Fee policies of New Jersey Cancer Care, PA

Signature: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient