Endocrinology Associates of Central NJ

Kenneth W. Ordene, M.D., F.A.C.P., F.A.C.E.
DIPLOMATE
AMERICAN BOARD OF ENDOCRINOLOGY AND METABOLISM
AMERICAN BOARD OF INTERNAL MEDICINE

Eric A. Wininger, M.D.
DIPLOMATE
AMERICAN BOARD OF ENDOCRINOLOGY AND METABOLISM

Welcome to Endocrinology Associates

- For your initial visit present a PHOTO ID such as a Drivers' license
- Bring your insurance card and an insurance referral *if* required by your insurance plan
- Insurance policies have become increasingly complex. It has become impossible to know each specific plan and their limitations. Therefore, it is your responsibility to know your insurance benefits.
- Please bring all the registration forms completed to your new patient visit. Do not mail them to our office –bring the forms with you to the visit.
- Bring Bloodwork results and/or Radiology *Reports* to your visit. You can also have these results faxed to our office. Our fax number is 732-308-0117
- If you are Diabetic and use a glucose meter –please bring your meter. We will download your meter at your visit.
- If you use a glucose logbook or form to document your blood sugar readings-please bring the log to your appointment

You are scheduled to see: * Dr. Kenneth W Ordene* * Dr. Eric A. Wininger*

On_____, _____at_____ am/pm

- Please arrive 10 minutes prior to your appointment time. If you do not have the new patient registration forms completed, please arrive 30 minutes before your appointment.
- It is Mandatory for you to contact your physician and have your medical records from the last 6 months faxed to our office PRIOR TO YOUR APPOINTMENT.
- All co-pays and account balances are due at the time of service. If your copay is not paid at the time of visit a $10 fee is added to your account.
- Using an automated system, we attempt to confirm patients' appointments 2 days prior. It is the responsibility of the patient to make sure the office has an up to date telephone number and address. This is just a courtesy call and it is ultimately the patients' responsibility to remember their appointment.
- A 48 HOUR cancellation is required for a new patient appointment. * If a new patient appointment is cancelled without a 48 Hour notice –a new patient appointment will not be rescheduled unless a patient leaves a credit card number.
- A 24 Hour notice is requested when cancelling a follow up appointment.

- OUR OFFICE IS LOCATED AT 501 IRON BRIDGE ROAD, SUITE 12, FREEHOLD N.J. 07728
- TELEPHONE# *732-780-0002 FAX# *732-308-0117 OUR WEBSITE IS: www.endonj.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name	First Name		
Home Address	City	State	Zip code
Home Phone	Work Phone	Cell Phone	
Date of Birth	Social Security #	Gender	
Occupation:			

EMERGENCY CONTACT INFORMATION:

Name	Relationship to Patient	
Home Phone	Work Phone	Cell Phone

REFERRING PHYSICIAN:

Name	Specialty
Office Address	
Office Phone Number	Office Fax Number

PRIMARY PHYSICIAN (IF DIFFERENT FROM REFERRING PHYSICIAN):

Name	Specialty
Office Address	
Office Phone Number	Office Fax Number

PRIMARY INSURANCE INFORMATION:

Insurance Company Name	Phone Number	Policy Effective Date
Policy Holder's Name	Policy Holder's Employer	
Relationship to Patient	Policy Holder's Date of Birth	Policy Holder's Gender
Policy Holder's Social Security Number		Group #

SECONDARY INSURANCE INFORMATION:

Insurance Company Name	Phone Number	Policy Effective Date
Policy Holder's Name	Policy Holder's Employer	
Relationship to Patient	Policy Holder's Date of Birth	Policy Holder's Gender

Endocrinology Associates of Central NJ

Kenneth W. Ordene, M.D., FACP, FACE
Eric A. Wininger, M.D.

WELCOME TO OUR OFFICE!
Please fill in forms to help with your visit.

Name:_____

Date:_____

Problem you are here for:_____
_____

Medical History: (Please Circle)

High blood pressure.....No Yes
Diabetes.....No Yes
Heart Disease.....No Yes
Cancer..... No Yes
Arthritis.....No Yes
Stomach Ulcer..... .No Yes
Eye Disease..... No Yes

Thyroid. (overactive, underactive, goiter).....No Yes
Kidney stones.....No Yes
Acute Infections..... No Yes
Venereal Disease..... No Yes
Hereditary defects.....No Yes
Bleeding tendency.....No Yes

Previous Hospitalizations/Surgeries

_____
_____
_____
_____
_____

Other Medical Problems:(Please list)

_____
_____
_____

Medications: (Name & Dose)

_____
_____
_____
_____
_____
_____
_____

Allergy to Meds:_____

Social History:

Marital status: Single___Married___Separated___Divorced___Widowed___
Use of alcohol: Never___ Rarely____ Moderate___ Daily____
Use of tobacco: Never___ Previously, but quit____ Current packs/day_____
Use of drugs: Never___ Type/Frequency_____ Occupation:_____

Family History:

	Age	Diseases
Father	____	_____
Mother	____	_____
Siblings	____	_____
	____	_____
Spouse	____	_____
Children	____	_____
	____	_____

Family history of: (please circle)
(state who)

Diabetes

Hypothyroidism Goiter

Hyperthyroidism

Reviewed by:_____ Date_____
All other systems negative

Endocrinology Associates of Central NJ

NAME:_____ **DATE:**_____

PLEASE CIRCLE YES OR NO TO **ALL QUESTIONS**

CONSTITUTIONAL SYMPTOM

Good general health lately.....	No	Yes
Recent weight changes.....	No	Yes
Fever.....	No	Yes
Night sweats.....	No	Yes

EYES

Eye disease or injury.....	No	Yes
Laser surgery.....	No	Yes
Blurred or double vision.....	No	Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing.....	No	Yes
Nose bleeds.....	No	Yes
Bleeding gums.....	No	Yes
Sore throat or voice change.....		
Swollen glands in neck.....		

CARDIOVASCULAR

Heart trouble.....	No	Yes
Chest pain or angina pectoris.....	No	Yes
Palpitations.....	No	Yes
Shortness of breath with walking.....	No	Yes
Shortness of breath lying flat.....	No	Yes
Swelling of feet, ankles or hands.....	No	Yes

RESPIRATORY

Chronic or frequent coughs.....	No	Yes
Spitting up blood.....	No	Yes
Shortness of breath.....	No	Yes
Asthma or wheezing.....	No	Yes

GASTROINTESTINAL

Loss of appetite.....	No	Yes
Change in bowel movements.....	No	Yes
Nausea or vomiting.....	No	Yes
Frequent diarrhea.....	No	Yes
Painful bowel movements or constipation.....	No	Yes
Rectal bleeding or blood in stool.....	No	Yes
Change in hat or glove size.....	No	Yes

GENITOURINARY

Frequent urination.....	No	Yes
Burning or painful urination.....	No	Yes
Blood in urine.....	No	Yes
Change in force of stream when urinating.....	No	Yes
Incontinence or dribbling.....	No	Yes
Kidney stones.....	No	Yes
Sexual difficulty.....	No	Yes
Male – testicle pain.....	No	Yes
Female – pain with periods.....	No	Yes
Female – irregular periods.....	No	Yes
Female – vaginal discharge.....	No	Yes

Female - # pregnancies_____ # miscarriages_____

MUSCULOSKELETAL

Joint pain.....	No	Yes
Joint stiffness or swelling.....	No	Yes
Weakness of muscles/joints...	No	Yes
Muscle pain or cramps.....	No	Yes
Back pain.....	No	Yes
Cold hands or cold feet.....	No	Yes

INTEGUMENTARY (skin, breast)

Rash or itching.....	No	Yes
Change in skin color.....	No	Yes
Change in hair or nails.....	No	Yes
Breast pain.....	No	Yes
Breast lump.....	No	Yes
Breast discharge.....	No	Yes

NEUROLOGICAL

Frequent/ recurring headaches	No	Yes
Lightheaded or dizzy.....	No	Yes
Convulsions or seizures.....	No	Yes
Numbness/tingling sensation	No	Yes
Tremors.....	No	Yes
Paralysis.....	No	Yes
Stroke.....	No	Yes
Head injury.....	No	Yes

PSYCHIATRIC

Memory loss or confusion...	No	Yes
Nervousness.....	No	Yes
Depression.....	No	Yes
Insomnia.....	No	Yes

ENDOCRINE

Glandular/hormone problem	No	Yes
Thyroid disease.....	No	Yes
Diabetes.....	No	Yes
Excessive thirst or urination...	No	Yes
Heat or cold intolerance.....	No	Yes
Skin becoming dryer.....	No	Yes

HEMATOLOGIC/LYMPHATIC

Bleeding/ Bruising tendency..	No	Yes
Anemia.....	No	Yes
Phlebitis.....	No	Yes

ALLERGIC / IMMUNOLOGIC

List all DRUG allergies

_____

_____

_____

Kenneth W. Ordene MD FACP,FACE **Eric A. Wininger, MD**

Reviewed by_____

ENDOCRINOLOGY ASSOCIATES OF CENTRAL NJ, PA

Patient Name: _____ DOB: _____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Endocrinology Associates of Central NJ, PA appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer if your insurance carrier denies any part of your claim.

I have read the above policy regarding my financial responsibility to Endocrinology Associates of Central NJ, for providing medical services to me. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Endocrinology Associates of Central New Jersey the full and entire amount of the bill incurred by me; or, if applicable any amount due after payment has been made by my insurance carrier.

CO-PAY POLICY

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter. There will be a $10 charge to cover our billing costs if a copay is not paid at the time of service. There will be a $25 charge for the return of personal checks for insufficient funds.

CANCELLATION / NO SHOW POLICY

Using an automated system, we attempt to confirm a patients' appointment 2 days prior to their visit. It is the responsibility of the patient to make sure the office has an up to date telephone number and address. This is just a courtesy call and is ultimately the patients' responsibility to remember their appointment. A 24-hour notice is requested when cancelling a follow up appointment. A 48 Hour cancellation is required for a new patient appointment. A new patient appointment will only be rescheduled if a patient leaves a credit card. The credit card will not be charged unless the patient is a no-show for his rescheduled new appointment or does not cancel at least 48 hours for the second new patient appointment. The charge is $150.

SELF PAY

If you do not have Health Insurance, you will be responsible for services rendered at Endocrinology Associates of Central NJ, PA. You must agree to pay Endocrinology Associates of Central NJ, PA for the full amount due at each visit. There will be a $25 charge for the return of personal checks for insufficient funds.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature: _____ Date: _____

BILLING QUESTIONS? For all billing questions, please call the billing department at (877)-698-1700

ENDOCRINOLOGY ASSOCIATES OF CENTRAL NJ, PA

Patient Name: _____ DOB: _____

DESIGNATION OF DISCLOSURE

Designation of Persons Who *Can* Receive My Health Information:

I designate the following persons listed below as authorized to receive my health information, and I agree that Endocrinology Associates of Central NJ, PA may disclose my health information to these persons. Endocrinology Associates of Central NJ, PA will disclose only information that is directly relevant to my healthcare as it pertains to my care with Endocrinology Associates of Central NJ, PA.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Designation of Persons Who *Cannot* Receive My Health Information:

The following persons are expressly **not authorized** to receive my health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

TELEPHONE AND WRITTEN COMMUNICATION

I understand that Endocrinology Associates of Central NJ, PA may attempt to contact me by telephone. By listing my telephone numbers below, I authorize Endocrinology Associates of Central NJ, PA to contact me at these numbers:

Home: (_____) _____ **Mobile:** (_____) _____

I authorize Endocrinology Associates of Central NJ, PA to leave a voicemail or answering machine message containing the following (must check one):

Detailed Health Information: _____ **Call-Back Number Only:** _____

I authorize Endocrinology Associates of Central NJ, PA to send me written communication via mail to the following (check all that apply):

My Home Address: _____ **My Work/Office Address:** _____

Patient/Guarantor Signature: _____ Date: _____

CONSENT TO TREAT

I AUTHORIZE ENDOCRINOLOGY ASSOCIATES OF CENTRAL NJ TO EXAMINE ME/THE PATIENT FOR WHICH I AM LEGALLY RESPONSIBLE.

MEDICAL INFORMATION AGREEMENT

1. I authorize release of information that may be required to process my insurance claim to my insurance company or government agency for payment of medical bills.
2. I authorize release of appropriate medical information to other doctors, hospitals or medical facilities participating in my care.
3. I authorize release of appropriate medical information including test results from other doctors, hospitals or medical facilities to Endocrinology associates of Central NJ in order to aid in my care/treatment.
4. **It is my responsibility to make sure my insurance information is updated as needed. If my insurance requires an insurance referral to be seen by a specialist, it is my responsibility to make sure that my referral is valid at the time of my office visits.**

PATIENT /GUARDIAN SIGNATURE _____ DATE_____

CONSENT TO SEND PRESCRIPTIONS ELECTRONICALLY:

I hereby give Endocrinology Associates of Central NJ and its affiliated providers permission to view my prescription information and history from all external sources. By signing this consent form, I agree that Endocrinology Associates of Central NJ can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers' for all treatment purposes.

Patient Signature_____ Date_____

MEDICATION REFILLS:

All refills are done based on patients' adherence to scheduled appointments and medical necessity. Please be prepared to review your medication refill needs at the time of your visit. Contact your pharmacy to request refills outside of scheduled appointments as prescription refills are done electronically to and from your pharmacy. Please call your pharmacy first for your refills. The pharmacy will contact the office. If you prefer mail order, please allow ample time for the order to be processed and received through the mail. * Please be aware medication refills are dependent on your compliance with seeing your doctor at regular intervals. No refills are done on Weekends.

ENDOCRINOLOGY ASSOCIATES OF CENTRAL NJ, PA

Patient Name: _____ DOB:_____

PATIENT PORTAL AUTHORIZATION

Endocrinology Associates of Central N J provides a patient portal website for the use of our established patients. A patient may receive access to the **PATIENT PORTAL** by providing your **E-Mail address**.

You are **NOT required** to use the patient portal or provide your e-mail.

Using the **PORTAL,** a patient can:

- Access limited chart information
- Review Laboratory results ordered by your physician in our office
- Review Medication lists

The interpretation of all lab work and radiology studies will take place ONLY at your scheduled office visit. Please do not call the office prior to your appointment to discuss any results.

Scheduling or Cancelling appointments cannot be done through the Portal

E-Mail Address (please print):_____

You will receive a form at the check out desk with a temporary password.

RACE/ETHNICITY/LANGUAGE

For the implementation of electronic health records, we are now collecting data on race, ethnicity and primary language from our patients. The purpose of collecting this data is to insure high quality care for all populations.

Completing this form is **optional**.

Race: (Check one below)

____Native American or Native Alaskan

____Asian

____Native Hawaiian

____Black or African American

____Caucasian

____Hispanic.

____Other Race.

____Other Pacific Islander.

____Unreported or refused to report

Ethnicity: (Check one only)

____Hispanic or Latino

____Not Hispanic or Latino

____Refused

Language other than English

_____