Welcome to Our Practice

Metropolitan Asthma and Allergy
Feryal Hajee MD

Registration Form
732 383 5554

Date _____ Home Phone _____ Cell Phone _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle____ Social Sec _____

Address _____ Email _____ DOB _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Employer Phone _____ Employer Address _____

Who may we thank for referring you? _____ Married Single Divorced Widowed Parterned

Emergency Contact Name _____ Phone _____

PRIMARY INSURANCE

Responsible Party Name _____ Relationship to Patient _____

Date of Birth _____ Social Security _____

Address if different from patient _____

City _____ State _____ Zip _____

ADDITIONAL INSURANCE

Responsible Party Name _____ Relationship to Patient _____

Date of Birth _____ Social Security _____

Address if different from patient _____

City _____ State _____ Zip _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents have coverage with _____ (insurance Name) and authroize payment directly to Dr Feryal Hajee of all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance, and for all services rendered to me or my dependents. I understand that I am responsible for any copayments, coinsurance, and/or deductibles I may have with my plan. The above named physician may use my health information and may disclose such information to above named insurance company for purpose of obtaining payment for services rendered. I authorize my signature on all insurance submissions.

Patient Signature _____ Dare _____

Print name of Patient, Parent or
Guardian Responsible _____ Relationship _____

Metropolitan Asthma & Allergy, PC
Feryal Hajee, MD

ALLERGY QUESTIONNARE

Please answer all applicable questions.
This is part of your medical history and is therefore confidential.

Name: _____ **Date of Birth:** _____ **Date:** _____

Primary Physician: _____ **Referred By:** _____

Briefly Describe your symptoms: _____

Frequency of Symptoms: _____ **Onset of Symptoms:** _____

Symptoms worse during (circle applicable) Jan. Feb. Mar. Apr. May June
July Aug. Sep. Oct. Nov. Dec.
Morning Afternoon Evening Night

Allergic reactions to: Drugs _____ **Foods** _____

Insect Stings _____ **Other** _____

Present Medications/Vitamins/Supplements: _____

_____

_____

Previous Allergy Evaluation (when & where): _____

Pharmacy Name & Town: _____

ENVIRONMENTAL HISTORY:

Residence Type House __ Condo __ Apartment __ Other (please specify __

Time at current residence ___ **Cooling system** Central __ Window units __

Heating System Forced air __ Radiators __ Baseboard __

Humidifier Central __ Portable __ **Does anyone in the home smoke** Yes __ No __

Flooring Wall to Wall Carpet __ Hardwood __ Area rugs __

Have you seen any Roaches __ Mice __ Mold __

Pets Number of Dogs __ Number of Cats __ Other (please specify) ___

Do pets spend time indoors? Yes __ No __ **In the bedroom?** Yes __ No __

HIPAA Notice of Privacy Practices

Metropolitan
Asthma and Allergy
34 Sycamore Ave, Suite 1A
Little Silver, NJ 07739

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

I acknowledge receipt of this notice:

Patient Name: _____

Signature: _____ Date: _____