408 New Brunswick Ave
Fords, NJ 08863

P: (732) 826 - 1609
F: (732) 826 - 0075

Rodolfo Maldonado MD LLC

Internal Medicine

www.MaldonadoMDNJ.com

PATIENT INFORMATION					
Last Name:		First Name:		Middle Name:	
Date of Birth:	Age:	Sex: ▫ Male ▫ Female		Marital Status: ▫ Sing ▫ Mar ▫ Div ▫ Sep ▫ Wid	
E-Mail Address:					
Phone Number:		Is this your... ▫ Cell ▫ House		Social Security Number:	
Street Address:				Apt:	Floor:
City:	State:	Zip Code:	Pharmacy Name & City:		
Occupation:	Employer Name:		Employer Phone Number:		
Race: ▫ Black or African American ▫ American Indian or Alaska Native ▫ White ▫ Asian ▫ Native Hawaiian or Other Pacific Islander			Ethnicity: ▫ Hispanic or Latinx ▫ Not Hispanic or Latinx		
Name of Primary Insurance:	Member ID of Primary Insurance:				
Name of Secondary Insurance:	Member ID of Secondary Insurance:				

EMERGENCY CONTACT		
Name of Emergency Contact 1:	Relationship:	Cell Phone Number:
Name of Emergency Contact 2:	Relationship:	Cell Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rodolfo Maldonado MD LLC to release any information required to process my claims.

Patient/Guardian Signature _____ *Date* _____

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PAST MEDICAL HISTORY

ALLERGIES

If you have no known allergies, please check the box to the right: ▢ No known allergies to report.

1. Medication: _____ Reaction: _____

2. Medication: _____ Reaction: _____

MAJOR MEDICAL ILLNESSES

	Yes	No		Yes	No		Yes	No		Yes	No
Cardiovascular disease	▢	▢	Autoimmune disease	▢	▢	Cancer	▢	▢	Hepatitis or liver disease	▢	▢
Heart failure	▢	▢	Rheumatoid arthritis	▢	▢	Chest pain	▢	▢	Epilepsy	▢	▢
Angina	▢	▢	Lupus	▢	▢	Chronic pain	▢	▢	Seizures or syncope	▢	▢
Arteriosclerosis	▢	▢	Asthma	▢	▢	Type 1 diabetes	▢	▢	Neurological disorders	▢	▢
Damaged heart valves	▢	▢	Abnormal bleeding	▢	▢	Type 2 diabetes	▢	▢	Stroke	▢	▢
Heart attack	▢	▢	Anemia	▢	▢	Eating disorders	▢	▢	Insomnia	▢	▢
Heart murmur	▢	▢	Hemophilia	▢	▢	Malnutrition	▢	▢	Mental health disorders	▢	▢
High blood pressure	▢	▢	AIDS or HIV infection	▢	▢	Gastrointestinal disease	▢	▢	Recurrent infections	▢	▢
Low blood pressure	▢	▢	Arthritis	▢	▢	Acid reflux/heartburn	▢	▢	Kidney problems	▢	▢
Congenital heart defect	▢	▢	Bronchitis	▢	▢	Ulcers	▢	▢	Night sweats	▢	▢
Mitral valve prolapse	▢	▢	Emphysema	▢	▢	Thyroid problems	▢	▢	Osteoporosis	▢	▢
Sinus trouble	▢	▢	Stroke	▢	▢	Depression	▢	▢	Sexually transmitted disease	▢	▢
Tuberculosis	▢	▢	Elevated cholesterol	▢	▢	Anxiety	▢	▢	Glaucoma	▢	▢
Pacemaker	▢	▢	Skin disorder	▢	▢	Irritable bowel syndrome	▢	▢	Headaches or migraines	▢	▢
Pericarditis	▢	▢	Urinary incontinence	▢	▢	Foot pain	▢	▢	Cataracts	▢	▢
Rheumatic heart disease	▢	▢	Constipation	▢	▢	Swollen neck glands	▢	▢	Rapid weight loss	▢	▢

PREVIOUS SURGERIES

If you have no known surgeries, please check the box to the right: ▢ No known surgeries to report.

Surgery: _____ Date: _____ Surgery: _____ Date: _____

SOCIAL HISTORY

Drink Alcohol: ▢ Currently ▢ Past ▢ Never How much and how often? _____

Smoker: ▢ Currently ▢ Past ▢ Never How much and how long? _____

Subs. Abuse: ▢ Currently ▢ Past ▢ Never What substance? _____

FAMILY MEDICAL HISTORY

Mother: ▢ Hypertension ▢ Diabetes ▢ Cancer ▢ Other (Please Specify): _____

Father: ▢ Hypertension ▢ Diabetes ▢ Cancer ▢ Other (Please Specify): _____

Sibling: ▢ Hypertension ▢ Diabetes ▢ Cancer ▢ Other (Please Specify): _____

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MEDICATION LIST

If you have no known medications, please check the box to the right: ▫ No known medications to report.

1. Medication: _____ Dosage: _____
2. Medication: _____ Dosage: _____
3. Medication: _____ Dosage: _____
4. Medication: _____ Dosage: _____
5. Medication: _____ Dosage: _____
6. Medication: _____ Dosage: _____
7. Medication: _____ Dosage: _____
8. Medication: _____ Dosage: _____
9. Medication: _____ Dosage: _____
10. Medication: _____ Dosage: _____

SPECIALISTS

If you have no known specialists, please check the box to the right: ▫ No known specialists to report.

Specialist Name: _____ Specialty: _____
Specialist Name: _____ Specialty: _____
Specialist Name: _____ Specialty: _____
Specialist Name: _____ Specialty: _____

PREVENTIVE CARE

When was your last... ▫ No known preventive care to report.

Colonoscopy: _____ COVID shot: _____
Endoscopy: _____ Flu shot: _____
Mammogram: _____ Tetanus shot: _____
Prostate exam: _____ Shingles shot: _____

To the best of my knowledge, the information provided above is accurate and complete.

_____ _____
Patient/Guardian Signature *Date*

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
    1. File a complaint with your provider or health insurer, or
    2. File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Providers and health insurers who are required to follow this law must keep your info private by:

- Teaching the people who work for them how your information may and may not be used or shared,
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your healthcare,
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
- To protect the public's health, such as reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.

Signature: _____ Date: _____

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Patient Responsibility

- I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, routine screening, or procedures performed.
- I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.
- I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.
- I understand and agree that it is my responsibility to know if my insurance requires a referral and that it is up to me to obtain the referral within a timely manner, and that it will take the office 24 hours to process the referral.
- I understand that if I am more than 15 minutes late to my appointment or if I do not show up, the doctor reserves the right to refuse service, I can be charged a no show fee of $25 per visit missed, and the office will reschedule me to the next available appointment.
- I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.
- If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.
- By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior consent. RMMD LLC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Printed Patient Name (and Guardian Name if applicable): _____

Patient or Guardian Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DOB:** _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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