Maryann Alessio, D.O., F.A.A.P.

PATIENT INFORMATION

Patient Name______________________________Date of Birth____/____/______
Address______________________________________Home Phone______________
City____________________State______________Zip Code_______Sex : Male Female
Work Phone_______________Cell Phone_____________Email_________________
Social Security #____________Marital Status : Single Married Widow Divorced Separated
Spouse____________________Date of Birth________________
Emergency Contact_______________________Relationship_________________
Home Phone_____________Cell Phone_______________Work Phone____________

RESPONSIBLE PARTY/SUBSCRIBER INFORMATION

Name_____________________Relationship_____________DOB_______SS#__________
Address___________________________City______________State______________
Zip Code______________Home Phone_______________Cell Phone______________

EMPLOYMENT INFORMATION

Company Name____
Address____Phone__________
City_______________________________State_____________Zip___________

INSURANCE INFORMATION-PLEASE PRESENT CARD

Primary___________________________Secondary_____________________________
Subscriber_________________________Subscriber____________________________
ID#______________________________ID#__________________________________
Group#___________________________Group#________________________________
Co-Pay $______Effective Date____________ Co-Pay $________Effective Date__________
Referral Required Yes No Referral Required Yes No

Referred By____

The above information is accurate and complete to the best of my knowledge. I will not hold my doctor or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

- I hereby consent to the treatment at this office. I realize that results of medical care cannot be guaranteed and that there may be complications resulting from treatment.
- I authorize my insurance company carrier to pay benefits to the medical provider and obtain records necessary to process claims.
- I realize I am responsible for all fees not covered by my insurance company.

Date__________Signature____________________________Relationship____________

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PEDIATRIC PATIENT QUESTIONNAIRE

PEDIATRIC – HISTORY SHEET

Child's Name________________________ Child's Birthdate______________ Child's Sex______________

Child's Father________________________ Child's Mother________________________

Child's Brothers/Sisters____

Child's Birthweight______________ Child's Birthlength______________ Child's Head Circ______________

Doctor delivering child________________________ Hospital child born in________________________

Type of Delivery: C-Section__________ Vaginally(normal)__________

Was your baby: breast fed__________ bottle fed__________ formula name______________

PREGNANCY HISTORY

	Yes	No
1. Smoking	___	___
2. Alcoholic Beverages	___	___
3. Infections	___	___
4. Medications/Drugs	___	___
5. Bleeding	___	___
6. Toxemia	___	___
7. High Blood Pressure	___	___
8. Premature Labor	___	___

9. Other____

PROBLEMS WITH NEWBORN

	Yes	No
1. Jaundice	___	___
2. Infections	___	___
3. Colic	___	___
4. Breathing problems	___	___
5. Feeding problems	___	___

6. Other______________________

At what age did your child: sit up__________ crawl__________ walk__________

FAMILY HISTORY

	Yes	No	Explain:
Diabetes	___	___	______________________
Asthma	___	___	______________________
Cancer	___	___	______________________
Cystic Fibrosis	___	___	______________________
Muscular Dystrophy	___	___	______________________
Heart Disease	___	___	______________________
High Blood Pressure	___	___	______________________
Sickle Cell	___	___	______________________
Anesthetic reaction	___	___	______________________
Bleeding disorder	___	___	______________________
Thyroid disease	___	___	______________________

Other____

CHILD'S ALLERGIES & MEDICATIONS

List All Medication Allergies____

Other Allergies environmental____

Present medications____

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SIGNIFICANT ILLNESSES/INJURIES | **YEAR**

Significant Illnesses/Injuries	Year

CHILD'S MEDICAL HISTORY

	Yes	No	Explain
1. Eye surgery			
2. Glasses			
3. Tonsillitis			
4. Ear infections			
5. Ear tubes			
6. Frequent "colds"			
7. Asthma			
8. Chronic cough			
9. Pneumonia			
10. Heart Disease			
11. Heart murmur			
12. Chronic skin rashes			
13. Thyroid disorder			
14. Diabetes			
15. Stomach pain			
16. Chronic constipation			
17. Chronic diarrhea			
18. Hepatitis			
19. Kidney/bladder infections			
20. Bedwetting over age 3			
21. Anemia			
22. Headaches			
23. Swollen or painful joints			
24. Chronic muscle aches			
25. Seizure disorder			
26. Behavior disorder			
27. Learning disorder			
28. Other			

CHILD CARE OUTSIDE THE HOME (explain)____________________

TESTS & IMMUNIZATIONS: Give date last done/ or please provide documentation

	Yes	Mo/Yr
1. Chest X-Ray		
2. CBC		
3. Fasting Blood Sugar		
4. Thyroid Profile		
5. Hearing Test		
6. Vision Test		
7. Blood Profile		
8. Urine Test		
Other________		
Other________		
Other________		

	Yes	Mo/Yr
9. DPT, Dose 1		
10. DPT, Dose 2		
11. DPT, Dose 3		
12. DPT, Dose 4		
13. DPT, Dose 5		
14. Polio, Dose 1		
15. Polio, Dose 2		
16. Polio, Dose 3		
17. Polio, Dose 4		
18. MMR		
19. TB		

GIRLS ONLY

Menstrual periods: Age of onset__________ Date of last period__________

Periods are: (circle one) Regular Irregular

PARENT/GUARDIAN____________________ DATE__________

MARYANN ALESSIO, D.O.
349 PASSAIC AVENUE
NUTLEY, NEW JERSEY 07110

Protected Health Information

Due to Federal HIPAA Laws, we can no longer leave messages without your consent regarding your Protected Health Information (PHI). Please check off **ALL** that apply:

1. _____**Home Phone #** ____________________
   _____Yes, you may leave a detailed message
   _____Leave message with call back number only
   _____Leave message regarding appointment information only

2. _____**Cell Phone #** ______________________
   _____Yes, you may leave a detailed message
   _____Leave message with call back number only
   _____Leave message regarding appointment information only

3. _____**Written Communication**
   _____You may mail to my home address _______________________________

4. _____You may discuss my medical information with the following persons:

   Name:_________________________________Relationship:___________

   Name:_________________________________Relationship:___________

   Name:_________________________________Relationship:___________

Appointment Cancellation Fees & Returned Check Fees

Effective March 1, 2004 we reserved the right to charge a missed appointment fee for appointments cancelled/missed without 24 hours notice. A message may be left on answering machine if office is closed. The fee for a routine/sick visit is $25.00 and the fee for physicals is $50.00 . Remember someone else could use that time who needs medical attention that day.

We reserved the right to charge a $25.00 service fee for all returned checks in addition to any Bank fee incurred. No checks will be accepted in the future. Cash or credit card only.

If you have any questions regarding the above office policy please feel free to discuss them with the office staff. Thank you in advance for your co-operation.

Patient Name: ____Date:_______________

Patient Signature:____

PATIENT CONSENT FORM

Maryann Alessio, D.O., P.A.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________

ITEM 070-6947/25941 © MAY 2002

Maryann Alessio, D.O., P.A.

New Jersey Department of Health and Senior Services
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-588-7512 (Fax 609-588-3642)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health and Senior Services (NJDHSS). The NJDHSS may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

Olde Towne Optimal Health

Maryann Alessio, D.O., F.A.A.P.
Board Certified Physician • Internal Medicine & Pediatrics

Dear Patients of Olde Towne Optimal Health:

Effective immediately, in an effort to provide efficient care and give our patients our fullest attention, we will reschedule patients who arrive **10 minutes or more** late for their scheduled appointment. You will be charged a missed appointment fee as agreed upon in your registration packet.

We will not see any patient without an appointment...Please call ahead if you would like an additional patient to be seen at the time of your appointment so we can better schedule you and other patients are not inconvenienced. Please understand that your time is scheduled for you so that you receive the attention you deserve and please refrain from asking medical advice or discussion of other family member's medical conditions at **your** scheduled appointment.

If you are scheduled for bloodwork only, you will not see the physician or nurse practitioner. If you need to be seen for any other complaints at that time, you will need to schedule an office visit with the physician or nurse practitioner. Any and all office visits including those with only the medical assistant will be required to pay a co-pay as per your insurance. Your co-pay is due at the time of your visit or services cannot be rendered.

Thank you for your co-operation.

Sincerely,

Maryann Alessio, D.O., F.A.A.P.

Effective June 15, 2011

______________________________ ______________________
Signature Date

349 Passaic Avenue, Nutley, N.J. 07110 • 973-667-8889 • Fax 973-667-5665

<u>**RECORDS RELEASE REQUEST**</u>

TO____

ADDRESS____

CITY___________________ STATE______________ ZIP________________

I hereby authorize the release of my medical records or copies of such and request that they are transferred to:

MARYANN ALESSIO, D.O., P.A.
349 PASSAIC AVE.
NUTLEY, N.J. 07110
973-667-8889
Fax# 973-667-5665

________________________________	________________________________
PATIENT NAME	**PATIENT SIGNATURE**