



732.287.0255 tel 732.287.0355 fax njheartcare@gmail.com www.njheartcare.com

Patient Information

Name:			Date of Birth:	
(Last)	(First)	(M)		
Address:			SS#:	
City:	State:		Zip Code:	
Home Phone:	Cell Phone:		Email:	
Sex:	Marital Status:			
Employer's Name:			Occupation:	
Address:			Work Phone:	
City:	State:		Zip Code:	
Insurance				
Name of Carrier:				
ID#:	Grou	Jp#:		
Subscriber:	Relationship:		Date of Birth:	
Emergency Contact:			Phone:	
	(Name & Relationship)			
Referred by:			Phone:	
services renendered by the	authorized medicare benefit physician. I authorize Dr. Arc	s be made c on A. Barsky t	on my behalf to Dr. Aron A. Barsky for any to release medical information to HCPA and e benefits payable for related services.	
	le to me to Dr. Aron A. Barsk		th my insurance company and assignment nd that I am financially responsible for any	
Signature:			Date:	
Advance Directive (Living W	/ill)· Yes or No			



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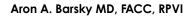
Medical/Family HistoryPlease check all that apply to either you and your family:

Alcoholism	You	Family	High Blood Pressure	You	Family	Stroke	You	Family
Anemia	You	Family	Kidney Disease	You	Family	Suicide Attempt	You	Family
Asthma	You	Family	Liver Disease	You	Family	Thyroid Disease	You	Family
Cancer/Tumor	You	Family	Hepatitis	You	Family	Tuberculosis	You	Family
Diabetes	You	Family	Lung Disease	You	Family	Ulcer in GI tract	You	Family
Drug Abuse	You	Family	Mental Illness	You	Family	Venereal Disease	You	Family
Depression	You	Family	Osteoarthritis	You	Family	High Cholesterol	You	Family
Epilepsy/Seizures	You	Family	Osteoporosis	You	Family	HIV/Immune Dx	You	Family
Glaucoma	You	Family	Phlebitis	You	Family	Other	You	Family
Heart Disease	You	Family	Rheumatic Arthritis	You	Family			

Review of Systems

Please check Yes or No to all that apply to you:

Constitutional:			Skin:			Endocrine:		
Weight Loss	Yes	No	Rash/Sores	Yes	No	Loss of Hair	Yes	No
Fatigue	Yes	No	Lesions	Yes	No	Heat/Cold Intolerance	Yes	No
Fever	Yes	No	Itching/Burning	Yes	No	Diabetes	Yes	No
						Thyroid	Yes	No
Eyes:			Respiratory:					
Glasses/Contacts	Yes	No	Cough	Yes	No	Hematology/Lympy:		
Eye Pain	Yes	No	Coughing Blood	Yes	No	Easy Bruising	Yes	No
Double Vision	Yes	No	Wheezing	Yes	No	Gums Bleed Easily	Yes	No
Cataract	Yes	No				Enlarged Glands	Yes	No
			Gastrointestinal:			History of Clot	Yes	No
Ear, Nose, Throat:			Heartburn/Reflux	Yes	No			
Difficulty Hearing	Yes	No	Nausea/ Vomiting	Yes	No	Musculoskeletal:		
Ringing in Ears	Yes	No	Constipation	Yes	No	Joint Pain/Swelling	Yes	No
Vertigo	Yes	No	Diarrhea	Yes	No	Stiffness	Yes	No
Sinus Trouble	Yes	No	Jaundice	Yes	No	Muscle Pain	Yes	No
			Abdominal Pain	Yes	No	Back Pain	Yes	No
Cardiovascular:			Black or Bloody BM	Yes	No			
Murmur	Yes	No				Neurological:		
Chest Pain	Yes	No	Genitourinary:			Loss of Strength	Yes	No
Palpitations	Yes	No	Burning/Frequency	Yes	No	Numbness	Yes	No
Dizziness	Yes	No	Nighttime	Yes	No	Headaches	Yes	No
Fainting Spells	Yes	No	Blood in Urine	Yes	No	Tremors	Yes	No
Shortness of Breath	Yes	No	Erectile Dysfunction	Yes	No	Memory Loss	Yes	No
Difficulty Lying Flat	Yes	No	Abnormal Discharge	Yes	No	History of Stroke	Yes	No
Swelling Ankles	Yes	No	Bladder Leakage	Yes	No			
Waking up Shortness						Psychiatric:		
of Breath	Yes	No	Allergic/Immunologic:			Anxiety/Depression	Yes	No
			Hives/Eczema	Yes	No	Mood Swings	Yes	No
			Hay Fever	Yes	No	Difficult Sleeping	Yes	No





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Current Medications

Date of Rx	Medication name Brand or generic name	Dosage mg, units, puffs, drops	When do you take it? How many times per day? Morning & night? After meals?	Purpose and prescribing doctor		
Preferred Pho	armacy:		Phone:			
Allergies to Medications Name of medication: Adverse reaction: Reason for Today's Visit						
	Information nildren					
Tobacco use	: Yes No Former Date	quit	How much? H	How long?		
Alcohol use: `	Yes No How many drink	ks per week?				
Caffeine (cof	fee, tea, soda) per day? _					
Approximate	date of last mammogram	N/A				
Approximate	Approximate date of last blood work?					





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Acknowledgment of Receipt of Notice

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES," revision date 04/14/03.

As required by the Privacy Regulations, Dr. Aron Barsky from this practice has explained the "Notice of Privacy Practices" to my satisfaction.

As required by the Privacy Regulations, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

I wish to file a "Request for Alte	riction" of my Protected Health information. rnative Communications" of my Protected Health information. g in the "Notice of Privacy Practices"
understand that this office may change the of the original/previous version(s).	eir Notice of Privacy Practices and is not required to honor the terms
Signature:	Date:
Print Name:	
(Official Use Only)	
Signed from received by:	Date:
	Signature
Good faith effort to obtain receipt. Describe	e: