

CENTER FOR NUTRITION AND PREVENTIVE MEDICINE

Today's date:		Referred by:		
Patient's last name:	First:	Middle:	Date of birth: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Marital status (circle one) Single / Mar / Div / Sep / Wid / Ptr	
City:	State:	Zip:	SSN: - -	
Home phone no.: ()	Cellular phone no.: ()		Occupation:	
E-mail address:			Employer:	
Name of insured (if different from patient):			Date of birth of insured: / /	
Primary insurance:		ID no.:		
Secondary insurance:		ID no.:		
Describe the problem or condition which prompted this visit:				
List any medications you are taking with their dosage and frequency:				
List any dietary supplements you are taking with their dosage and frequency:				
Do you have any allergies to medication or other substances? If so please list:				
List any operations and their dates:				
List any major or serious illnesses you have had (heart attack, diabetes, cancer, measles, etc.) and their dates:				
List any accidents or injuries and their dates:				
List number of pregnancies:		Births:	Last menstrual period:	
Irregular? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of last: Pap smear:	Mammogram:	Chest X-ray:	Colonoscopy:	Bone density test:
If any family members have had the following disorders please list them below:				
Cancer	Type	Heart Disease (heart attack, stroke, etc.)	Diabetes	Obesity

Have you had: Flu vaccine? Yes No Date ___/___/___ Pneumonia vaccine? Yes No Date ___/___/___
 Tetanus vaccine? Yes No Date ___/___/___ Hepatitis B vaccine? Yes No Date(s) ___/___/___, ___/___/___, ___/___/___
 Do you smoke? Yes No How many packs / day? _____ For how many years? _____ Quit _____ years ago.
 Do you drink alcoholic beverages? Yes No What type? _____ How much daily? _____
 Do you drink coffee? Yes No Type? _____ # cups / day? _____
 Do you drink tea? Yes No Type? _____ # cups / day? _____
 Do you drink colas? Yes No Type? _____ # cups / day? _____
 Are you presently following any type of special diet? Yes No

Please describe it: _____

Are there any foods you cannot or will not eat? Yes No Please list them: _____

Do you exercise regularly? Yes No How many minutes daily? _____

What activities do you engage in? _____

Classify your weight control: No problem, can eat anything
 Minor problem, amenable to self-control
 Major problem, numerous diets, ups and downs

What diets have you tried, if any? _____

Minimum weight as an adult: _____ lbs. at age: _____

Maximum weight as an adult: _____ lbs. at age: _____

Have you had any of the following conditions or problems? (If yes, please check and circle as appropriate. Add any additional pertinent comments.)

Nearsighted, farsighted, presbyopia, cataracts	Abdominal pain
Glaucoma, trouble seeing at night	Constipation
Double vision	Diarrhea
Difficulty with hearing	Unusual bowel movements (bleeding, dark black,
Ringling in ears	Floating, greasy, etc., other)
Dizziness	Liver disease (hepatitis: type A, B, C, jaundice)
Stuffed nose, allergies (What time of year? _____)	Gallbladder disease
Headaches, type _____ frequency _____	Ulcer, type: _____
Seizures	Other gastrointestinal disease
Numbness, tingling, pins and needles sensation	Kidney disease (infections, stones, bleeding, other)
Weakness, fatigue (how long? _____)	Bladder or prostate problems (trouble urinating, slow,
Cardiovascular disease (heart attack, stroke,	urination at night, (# times ___/night, burning)
hypertension, angina, atherosclerosis, palpitations,	Blood disorders (anemia, prolonged bleeding, etc.)
arrhythmia, heart murmur, other)	Diabetes, type: _____ Year of onset _____
Difficulty breathing, coughing, wheezing	Thyroid disease Type _____
Asthma	Arthritis or gout (describe where) _____
Bronchitis, emphysema	Lipid disorder (high cholesterol, high triglycerides)
Trouble swallowing, painful swallowing	Sexually transmitted diseases: herpes, Chlamydia,
Nausea	gonorrhea, syphilis, HPV, HIV
	Low sex drive, erection difficulty
	PMS, menopausal symptoms, describe _____

Do you have any other disease or condition not listed above that we should know about? Please list and explain: _____

Gary A. Klingsberg, D.O. ≡|||≡|||≡|||≡|||≡|||≡|||≡|||≡|||

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“NON-COVERED SERVICES”

I hereby acknowledge by this statement that I have been fully informed that some, and perhaps all of the medical services provided by Dr. Klingsberg throughout the course of my treatment may be “non-covered” services and not considered reasonable and necessary under the Medicare program and/or other medical insurance programs for the reasons set forth in the plans. I realize that my insurance carrier and/or Medicare will not pay for such “non-covered” services and that I will be personally responsible for payment for all such “non-covered” services.

Patient’s signature

Witness

Date

ASSIGNMENT OF BENEFITS

I authorize payment of medical insurance benefits to Dr. Gary Klingsberg for medical services rendered.

Although I have assigned benefits to Dr. Gary Klingsberg, I fully understand that the ultimate responsibility for payment of fees for services (including any applicable deductible or co-payment) is mine. I further understand and agree that if an assigned insurance payment is sent by the insurance company as a matter of policy or error to me, I will endorse the insurance company’s check to and deliver it to Dr. Gary Klingsberg, along with a copy of the explanation of benefits that the insurance company has provided to me.

Patient’s signature

Print name

Date

Insurance Company

Policy number

CENTER FOR NUTRITION AND PREVENTIVE MEDICINE

DR. GARY KLINGSBERG

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 & 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 received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 on the Notice 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.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE:

INITIALS:

REASON: