Ventnor Wellness
Registration Form

Today's Date:					
PATIENT INFORMATION					
Patient's First name:	Middle:	Last:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security #:	Birth date:	Age:	Sex: ☐ M ☐ F
Street address:	City:	State:	Zip Code:		
Home Phone:	Cell Phone:	Email:			
Occupation:	Employer:	Employer phone no.:			
Chose clinic because/referred to clinic by :					

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a patient here?	☐ Yes	☐ No			
Occupation:	Employer:	Employer address:	Employer phone no.:		
Is this patient covered by insurance?	☐ Yes	☐ No			
Name of Primary ins. and address:					
Subscriber's name (if different from above):	Subscriber's SS no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Accident Date (if applicable):		State of Accident:		Adjuster's Name:	
Name of secondary ins. (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

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 Robert Michael Grife Enterprises LLC / Ventnor Wellness or insurance company to release any information required to process my claims.

Patient/Guardian signature   *Date*

Ventnor Wellness

New Patient Health Questionnaire

Name:______________________________________ Date:____________________

DOB:______________________ Age:_________ New Patient_____ Established _____

PLEASE NOTE: **This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.**

What medical concerns bring you to our office? ____

Marital Status: *(circle)* S M D W Occupation: *(if retired, previous occupation)*____________________________

If disabled, check here:_____ Nature of disability______________________________Birthplace: ______________

Do you exercise routinely? *(circle)* No Yes If *Yes*, what exercise/how often?_____________________________

Have you ever smoked? *(circle)* No Yes Cigar Pipe Cigarettes If *Yes*: #cigarettes/day__________#yrs.__________

If you have never smoked, skip this question: Do you still smoke now? *(circle)* No Yes If *No*, when did you quit?__________

Have you completed Advanced Directives or do you have a Living Will? *(circle)* No Yes Which? ______________

Caffeine: Do you drink *(circle)* caffeinated coffee, teas or sodas regularly? *(circle)* No Yes #/day ______________

Tell us a little about your home environment: *(e.g. live alone, with family, single parent, house, apt., etc.)*

____

Are you under a lot of pressure at work or at home? *(circle)* No Yes, Which?_____________________________

Medical Information

Allergies: Are you allergic to any drugs? *(circle)* No Yes Please list:_____________________________________

Medications *(List all medications and the dosage. Include over the counter, herbal or natural remedies.)*

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Medical Illnesses or Conditions *(list any chronic conditions which you have been diagnosed to have)*

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Have you ever had or been diagnosed to have: *(check box by all that apply)*

Cataracts		Heart Disease		Ulcers		Anemia		Depression	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Frequent Infection	
Asthma		High Blood Pressure		Hemorrhoids		Bone or Joint Disease		Cancer (type)	
Allergies		Pneumonia		Kidney Disease					
Stroke		TB/Lung Disease		Kidney Stone(s)		German Measles		High Cholesterol	
Seizures/Epilepsy		Pleurisy		Diabetes or PreDiabetes		Rheumatic Fever		Prostate Enlargement	
Heart Attack or Angina		Jaundice or Liver Disease				Chicken Pox			
				Thyroid Disease		Syphilis			

Operations:
Please list any surgery and approximate year

Year	Surgery

Hospitalizations:
Other than operations

Year	Reason	Hospital

Family Medical History	Age	Health *(list significant illness)*	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brothers or Sisters					
Spouse					
Children					

Has any blood relative ever had? (*check if Yes and indicate relationship*)

___ Alzheimer's______________ ___Heart Attack before age 55_____ ___Alcoholism______________
___ Tuberculosis______________ ___Bleeding Disease____________ ___Mental Disorder___________
___ Diabetes______________ ___Stroke______________ ___Allergies______________
___ High Blood Pressure__________ ___Seizures______________ ___Asthma______________
___ Heart Disease______________ ___Depression/Suicide___________ ___Cancer______________

____

Immunizations (*check if Yes and indicate year of last injection*)

___ Influenza______________ ___Pneumonia______________ ___MMR ______________
___ Tetanus______________ ___Hepatitis A or B______________ ___Other ______________

Transfusions: Have you ever had a blood or plasma transfusion (*circle*) No Yes

Weight: What is your weight now? _______ One year ago? _______ Maximum? _______ When? _______

Females Only: Are you pregnant, planning a pregnancy or nursing a child? (*circle*) No Yes

Date of last menstrual period?______________________

VENTNOR WELLNESS NO SHOW AND CANCELLATION POLICY

Patients who do not keep their appointments or provide 24 hour notice of cancellation will be subject to a charge of $25.00. This fee will be applied after the second missed appointment or second failure to provide 24 hour notice of cancellation within a 12 month period. This is not a billable charge to any insurance company and is the responsibility of the patient. If a patient misses or cancels 3 times without proper notification, we reserve the right to dismiss that patient from the care of Ventnor Wellness.

VENTNOR WELLNESS FINANCIAL POLICY

Charges incurred for services rendered by the Ventnor Wellness are the patient's responsibility, regardless of insurance coverage. It is the patient's responsibility to provide this office with accurate insurance information, and to notify us of any changes in health insurance coverage. If you have questions on network status/participation with your insurance, it is your responsibility to contact the customer service number on your insurance card.

Patient responsibility: If your insurance has an office co-payment, co-insurance, or deductible that has not been satisfied, you must pay this at the time of your appointment.

Authorization: If your insurance company requires authorization to see a specialist, it is your responsibility to contact your primary care physician and request the authorization. Always check with your insurance before your appointment date and make sure the authorization has been approved. If no approved authorization is on file, you are responsible for the entire bill.

Billing: Know your insurance policy. You are responsible for any rejected claims, non-covered expenses, deductibles, co-insurance. Our statements are sent monthly. Cash, check, money order or all major credit cards are acceptable means by which to pay the balance. If there remains an unpaid balance and we receive no payment or contact from the responsible party despite all our efforts to contact said party, then the account could be turned over to a collection agency or pursued legally. There is a $35.00 fee for checks that are returned for insufficient funds. Informing our patients about our financial policy assists us in providing the best service to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please kindly contact our Business Office Supervisor.

I hereby understand the financial policy of this practice. I guarantee payment of all charges incurred for the account of the patient named below. I further agree to pay any attorney's fees, court costs, and related collection fees incurred. I also agree that my employer may be contacted to verify employment status.

Print Patient name: ____________________________________ Date: __________________

Patient Signature: ____

Ventnor Wellness

6601 Ventnor Avenue, Ventnor City, NJ 08406
(609) 350 6680

CONSENT FOR TREATMENT

I authorize the healthcare providers employed by Ventnor Wellness to provide medical care and administer the necessary treatment as described to me. Such care and treatment may include medical care, chiropractic care, and physical therapy.

I have been informed of the risks and complications that may occur from such treatment and the alternative treatments that may be available.

I have not been given any guarantee of the results or outcome of my treatment.

I authorize the release of medical information necessary to process a claim through my health insurance carrier.

I agree to pay any bill arising from my care that my health insurance carrier does not cover.

I understand that Ventnor Wellness is not participating with my health carrier and therefore my claims will be processed at the out of network rate.

Ventnor Wellness has made their Notice of Privacy Practices available to me.

I confirm that I have read and fully understand the above statements.

X_______________________________________ ______________________
Signature of Patient or Legal Representative Date

_______________________________________ ______________________
Printed Name of Patient or Legal Representative Relationship to Patient

X_______________________________________ ______________________
Signature of Witness Printed Name of Witness

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Ventnor Wellness
Effective: May 1, 2018
Initial Acknowledgement and Uses

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Ventnor Wellness. Our Notice of Privacy Practices provides information about how we may use and disclose you protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Katie Ayers.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Katie Ayers
You can reach the Privacy Official at:
Ventnor Wellness
6601 Ventnor Avenue #12
Ventnor City, NJ 08406
Phone number: 609-350-6680

Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Print Patient Name: ______________________________

Signature Patient/Personal Representative: ___________________________

Relationship of Personal Representative: ______________________________

Date of Signature: _________________

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Staff complete only if NO signature is obtained, if it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

□ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices

□ Other: ____

Staff Signature: ____Date: ____________________