MINIMALLY INVASIVE SURGEONS OF SOUTH JERSEY, LLC
MICHAEL P. DEL ROSARIO, MD
76 WEST JIMMIE LEEDS RD., SUITE 105
GALLOWAY, NJ 08205
609-652-3655
FAX: 609-652-7868

PATIENT REGISTRATION

Thank you for choosing our office. In order to serve you properly, we ask that you complete the following information. **Please print.** All information will be confidential.

Today's Date_____

Name_____ Date of Birth_____

Address_____ SS #_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____ Work Phone _____

Email address _____

Male_____ Female_____ Single_____ Married_____ Divorced_____ Widowed_____

Employer_____Occupation_____

Work Address_____

Emergency Contact_____ Phone_____
Relationship

Primary Care Doctor _____ Location_____ Phone_____

Pharmacy _____ Location_____ Phone _____

Cardiologist_____Phone_____ Pulmonologist_____Phone_____

Gastroenterologist_____Phone_____

Insurance Information

If insurance is in patient's name, please provide office with copy of insurance card and check here._____No other information needs to be completed in this section other than co-payment amount_____. **Referral needed?** YES NO

If patient is **NOT** the subscriber, please complete the following:

Name of Insured_____ Relationship to patient_____

Address (if different than above) _____

Phone_____ Date of Birth_____ Social Security #_____

I authorize release of any information regarding my health care and treatment for the purpose of determining insurance benefits and obtaining payment for services rendered. I assign all insurance benefits payable directly to Dr. Michael Del Rosario. I understand that I am financially responsible for all charges not paid by insurance.

_____ _____
Signature of Patient Date Signed

HEALTH HISTORY

All information will be kept confidential.

Patient Name_____ Height_____ Weight_____

Reason for visit_____

Referring physician_____

MEDICATIONS: Please provide a record of any medications you are taking, prescription or herbal or over the counter.

_____

_____

_____

ALLERGIES:_____

Please circle: **Location**-skin/local/systemic **Reaction**-rash /cough/runny nose/nausea/vomiting **Severity**-mild/moderate/severe

Do you have an Advance Directive (Living Will)? _____

MEDICAL/SURGICAL HISTORY or CONDITIONS: *Please check all that apply.*

[] Anemia
[] Asthma
[] Arthritis
[] Cancer of _____
[] Diabetes
[] Depression
[] Gallbladder disease
[] Heart disease
[] Hemorrhoids
[] Hernia
[] High blood pressure
[] HIV/AIDS
[] Kidney/bladder disease
[] Liver disease, hepatitis, jaundice
[] Lung disease, COPD, sleep apnea
[] Stroke
[] Thyroid disease
[] Stomach ulcer/GERD
[] Other _____
[] Other _____

SURGERY/HOSPITALIZATIONS

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY: Please include any serious/chronic diseases.

	Age	Health Status/Problem	If deceased, age and cause
Mother			
Father			
Brothers			
Sisters			

HEALTH HABITS: Please check and indicate usage.

Tobacco / Smoking	Cigarettes per day = or Packs per day =
Alcohol	[] social drinker or Drinks per day =
Other drug use	Marijuana / Other =
Caffeine	Cups per day =

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By my signature below I hereby acknowledge that I have received and reviewed a copy of this office's NOTICE OF PRIVACY PRACTICES.

_____

Name of Patient or Representative (Please Print)

_____

Patient or Representative Signature

_____

Staff Witness Signature

_____

Date

Email Communication Consent Form

For the ease of our patients, our office would like to offer the opportunity to communicate by email for billing purposes. Transmitting patient billing information poses several risks and the patient should not agree to communicate with the physician's office via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Email senders can misaddress, resulting in it being sent to many unintended recipients.
- Employers/online services may have a legal right to inspect and keep emails that pass through their system.
- Even after deletion of the email, back-up copies may exist on a computer.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email.

Our office will use reasonable means to protect the security and confidentiality of email information sent and received—however, we cannot guarantee the security of email communication. Thus, patients must consent to the use of email for patient information, billing, and communication.

Patient Acknowledgment and Agreement

I acknowledge that I have read, and fully understand this consent form. I understand the risks associated with the communication of email between the office and me, and consent to the conditions outlined herein, as well as any other instructions that the office may impose to communicate with patients by email. I acknowledge the physicians' right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered.

Patient Name: _____

Patient Email: _____

Patient Signature: _____

Date: _____