Atlantic Health System
Atlantic Medical Group

David & Joan Powell Center for Healthy Aging

GERIATRIC ASSESSMENT CENTER PATIENT HISTORY

973-971-7022

PATIENT INFORMATION:

Last Name: _____ E-Mail Address: _____

First Name: _____ Sex: _____

Date of Birth: _____ Religion: _____

Address: _____ Marital Status: _____

City: _____ Occupation: _____

State: _____ Zip: _____ Primary Language: _____

Home Phone: _____ Ethnic Origin: _____

Cell Phone: _____ Race: _____

WILL YOU BE COMING HERE FOR PRIMARY CARE? ☐ **YES** ☐ **NO**

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

What is your GOAL for today's visit?

MEDICATIONS

PHARMACY: PLEASE LIST YOUR PHARMACY NAME, ADDRESS & PHONE NUMBER

Local Pharmacy Name: _____

Address: _____

Phone: _____

Mail Order Pharmacy Name: _____

Address: _____

Phone: _____

CURRENT MEDICATIONS: * PLEASE BRING ALL MEDICATIONS TO YOUR APPOINTMENT *

PLEASE LIST OR ATTACH A COPY OF ALL YOUR PRESCRIPTIONS, SUPPLEMENTS HERBS AND/OR NATURAL PRODUCTS

MEDICATION NAME	DOSE	FREQUENCY

ALLERGIES or intolerance to medications or food (include type of reaction):

VACCINATIONS check if you have had the following:

☐ TDAP Date: _____ ☐ Pneumonia Date: _____

☐ Flu Date: _____ ☐ Shingles Date: _____

HEALTH MAINTENANCE check and list dates of the most recent preventive services you have received:

☐ Colonoscopy Date of last test: _____ ☐ Never Performed

☐ Dexa Bone Scan Date of last test: _____ ☐ Never Performed

☐ Eye (ophthalmology) exam Date of last test: _____ ☐ Never Performed

☐ Mammogram Date of last test: _____ ☐ Never Performed

☐ Dental evaluation Date of last test: _____ ☐ Never Performed

☐ Urology/ PSA Date of last test: _____ ☐ Never Performed

MEDICAL HISTORY

HISTORY OF HOSPITALIZATIONS (Date, hospital, reason for admission, MD):

_____

_____

_____

_____

Past Surgical history: please check whether you have ever had the following

- ☐ Appendectomy
- ☐ Brain surgery
- ☐ Breast surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colon surgery
- ☐ Cosmetic surgery
- ☐ Carotid artery surgery
- ☐ Fracture surgery
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Prostate surgery
- ☐ Pacemaker/ Defribilator
- ☐ Spine surgery
- ☐ Valve surgery
- ☐ Vascular surgery
- ☐ Other surgery/ procedure:

_____

CURRENT HEALTH SITUATION

CURRENT *OR* PRIOR HEALTH PROBLEMS:

Head/ Ears/ Nose/ Throat:
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Allergies
- ☐ Sinus infections

Cardiac
- ☐ Anemia
- ☐ Angina
- ☐ Afib
- ☐ Blood clots
- ☐ CHF
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood pressure
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Irregular heart rate

Behavioral/ Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Substance abuse
- ☐ Alcohol abuse

Neurological
- ☐ Alzheimer's
- ☐ Balance issues
- ☐ Dementia
- ☐ Memory Loss
- ☐ Parkinson's
- ☐ Seizures
- ☐ Strokes

Orthopedic
- ☐ Arthritis
- ☐ Fractures
- ☐ Spinal stenosis

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis

Oncology
- ☐ Cancer

Endocrinology
- ☐ Diabetes
- ☐ Thyroid disease

Gastrointestinal
- ☐ Diverticulosis
- ☐ Gall stones
- ☐ GERD
- ☐ Indigestion
- ☐ Stomach Ulcers
- ☐ Intestinal Ulcers
- ☐ Pancreatitis

Genitourinary
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Urinary retention
- ☐ Urinary incontinence
- ☐ Sexually transmitted infections
- ☐ Gout

Other:

FALL RISK ASSESSMENT

HAVE YOU EVER HAD A FALL? ☐ **YES** ☐ **NO**

FAMILY HEALTH HISTORY

	MOTHER	FATHER	SISTER	BROTHER
HEART DISEASE				
DIABETES				
HYPERTENSION				
DEPRESSION				
CANCER OF _____				
DEMENTIA				
ALZHEIMER'S DISEASE				
STROKE				
THYROID ISSUES				
OTHER				

OTHER DOCTORS PATIENT SEES REGULARLY (SPECIALISTS):

NAME	SPECIALTY	PHONE NUMBER

Do you smoke? ☐ YES ☐ NO Did you smoke? ☐ YES ☐ NO

Cigarettes/Day _____ When did you quit? _____

Do you drink? ☐ YES ☐ NO Did you drink? ☐ YES ☐ NO

Glasses/Day _____ When? _____

<u>INSURANCE</u>: *** PLEASE BRING ALL INSURANCE CARDS TO YOUR APPOINTMENT ***

PRIMARY INSURANCE	
LAST NAME	
FIRST NAME	
RELATIONSHIP TO PATIENT	
INSURANCE NAME	
INSURANCE ID #	
GROUP #	
SECONDARY INSURANCE	
LAST NAME	
FIRST NAME	
RELATIONSHIP TO PATIENT	
INSURANCE NAME	
INSURANCE ID #	
GROUP #	
ADDITIONAL INSURANCE *(if applicable)*	
LAST NAME	
FIRST NAME	
RELATIONSHIP TO PATIENT	
INSURANCE NAME	
INSURANCE ID #	
GROUP #	

SOCIAL HISTORY

Please describe your current living situation:

☐ House ☐ Apartment ☐ Condo ☐ CCRC ☐ Assisted Living ☐ Nursing Home ☐ Other _____

DO YOU LIVE ALONE? ☐ **YES** ☐ **NO**

IF NO, who do you live with?

NAME_____ RELATION _____

NAME_____ RELATION _____

NAME_____ RELATION _____

How many levels are in your home? _____

How many stairs to enter into the home? _____

Is your bathroom easily accessible? ☐ Yes ☐ No

Do you have any of the following Home Modifications?

☐ Grab Bar
☐ Shower Bench
☐ Ramps
☐ Stair Chair Lift
☐ Raised Toilet seat
☐ Other _____

Are you currently driving? ☐ Yes ☐ Yes but not on highways ☐ Yes but not at night ☐ No

Who is your closest family member or primary support person?

Name_____ Relation _____

IF NEEDED - Who else is available to help you on a daily basis? _____

Is anyone causing you to be afraid? ☐ Yes ☐ No

Is anyone physically or emotionally abusing you? ☐ Yes ☐ No

Is anyone financially exploiting / using your money without your permission? ☐ Yes ☐ No

Advance Directives ☐ **Request information**

Living Will ☐ No ☐ Yes* Healthcare Proxy ☐ No ☐ Yes* POLST ☐ No ☐ Yes*

*If yes, have documents been updated in the last 5 years? ☐ No ☐ Yes Date of POLST: _____

Behavioral Health Services ☐ **Request information**

Counselor ☐ No ☐ Yes If yes, name of Counselor: _____

Psychiatrist ☐ No ☐ Yes If yes, name of Psychiatrist: _____

Grief / Bereavement Services ☐ No ☐ Yes Support Group ☐ No ☐ Yes, type _____

Adult Day Care Center: ☐ **No** ☐ **Yes*** ☐ **Request information**

*If yes, name of Center: _____ Days per week _____ Hours per day _____

Home Health Aides / Companions ☐ **No** ☐ **Yes*** ☐ **Request information**

*If yes, name/agency: _____ Days per week _____ Hours per day _____

Case Management (county) ☐ **No** ☐ **Yes*** ☐ **Request information**

*If yes, case manager name: _____ County: _____

Private Geriatric Care Manager ☐ **No** ☐ **Yes*** ☐ **Request information**

*If yes, case manager name: _____ Agency: _____

Social Service Programs – do you currently receive any of the following benefits:

Medicaid / MLTSS	☐ No	☐ Yes	☐ Request Information
SNAP (Supplemental Nutrition Assistance Program)/ Food Stamps	☐ No	☐ Yes	☐ Request Information
PAAD (Prescription Assistance to the Aged and Disabled) or Senior Gold	☐ No	☐ Yes	☐ Request Information
JACC (Jersey Assistance for Community Caregiving)	☐ No	☐ Yes	☐ Request Information
Statewide Respite Care Program	☐ No	☐ Yes	☐ Request Information
LIHEAP/ USF (Energy Assistance)	☐ No	☐ Yes	☐ Request Information
Veteran's Aid and Attendance Pension Benefits	☐ No	☐ Yes	☐ Request Information

Please check if you would like information about the following:

☐ Senior Housing
☐ Assisted Living Facilities
☐ Nursing Homes / Skilled Nursing Facilities
☐ Home Modifications
☐ Medical Alert Systems
☐ Wandering / Safety concerns (Dementia)
☐ Home Delivered Meals / Meals on Wheels
☐ Family Caregiver concerns
☐ Family Caregiver support (i.e. support groups)
☐ Respite Care
☐ Elder Law Attorneys
☐ Health & Fitness Programs / AHS New Vitality
☐ Senior Centers
☐ Adult Schools
☐ Transportation
☐ Driving Assessments
☐ Other: _____

THIS QUESTIONNAIRE MUST BE SIGNED AND DATED

This Registration Form Was Completed By: _____

Relation to Patient: _____ **Today's Date:** _____

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DT104

PATIENT/FAMILY CONTACT LIST

Patient's Name: _____ DOB: _____

Contacts

People who have permission to receive detailed information about your care (PHI):

PRIMARY CONTACT

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

SECONDARY CONTACT(S)

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

☐ **I decline to designate a representative at this time.**

Comments/Other Information:

_____

_____

_____

_____

This form is effective upon execution and will remain in effect unless revoked by me.

Patient Signature: _____ Date: _____ Time: _____

Atlantic
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MEDICARE SECONDARY PAYOR QUESTIONNAIRE

MSP Questionnaire PART I

1. **Is the patient receiving Black Lung Benefits?** ☐Yes ☐No Date Began: _____
   {If yes, Black Lung is primary only for claims related to Black Lung}

2. **Are the services covered by a government research program such as a research grant?**
   {If yes, government research program will pay primary benefits for these services.} ☐Yes ☐No

3. **Has the Department of Veteran's Affairs authorized and agreed to pay for care at this facility?** ☐Yes ☐No
   {If yes, DVA is primary for these services}

4. **Is the illness or Injury due to a work related accident/condition?** ☐Yes ☐No Date: _____
   Name and address of worker's compensation (WC) plan:

   Worker's Compensation Policy or identification number:

   Name and address of your employer:

   {If yes, WC is primary payer only for claims related to work related injuries or illness, go to Part III}

MSP Questionnaire PART II

1. **Is the illness/Injury due to a non-work related accident?** ☐Yes ☐No
   {if no go to Part III}

2. **Did an auto accident cause the illness/injury?** ☐Yes ☐No Accident Date: _____
   Name and address of no-fault/Liability Insurance and no-fault insurance policy owner:

   Claim #
   {If yes, no-fault insurer is primary only for claims related to the accident, go to Part III}

3. **If another party was responsible for the accident, is liability insurance available?** ☐Yes ☐No
   Name and address of liability insurer and responsible party:

   Claim #
   {If yes, liability insurer is primary for claims related to the accident, go to Part III}

MSP Questionnaire PART III

1. **Are you entitled to Medicare based on:** ☐AGE ☐ESRD ☐DISABILITY
   {If AGE please complete part IV, If Disability please complete part V, If ESRD please complete part VI}

MSP Questionnaire PART IV-AGE

1. **Is the patient currently employed?** ☐Yes ☐No, Retirement Date: _____ ☐Never Employed
   Employer Name, Address & telephone #

2. **Is the spouse currently employed?** ☐Yes ☐No, Retirement Date: _____ ☐Never Employed ☐No Spouse
   Spouse's Employer Name, Address & Telephone

If the patient answered "No" to both questions, Medicare is primary unless the patient answered "Yes" to one of the above questions.

3. **Does the patient have Health Insurance coverage based on own or spouse's current employment?** ☐Yes ☐No
   {If no, Medicare is primary payor unless the patient answered yes to the questions in Part I or II}