Patient Information Sheet

(Please Print)

Patient Name:_____ Sex:_____ Marital Status: M S W D

Date of Birth:_____ Social Security#:_____

Address:_____ Email address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

**** To protect your privacy, may we use the: address, email, and phone number for written and oral communications? Yes / No**
May we add your email address to our list? Yes / No

If no, please provide an address for written communication*:_____
(*Required field to ensure payment)

Who referred you here?:_____ May we thank them?_____

Occupation/Employer:_____

Spouse's Name:_____ Date of Birth_____

Parent/ Guardian's name & relationship (if applicable):_____

Pharmacy Name:_____

Insurance Information

Primary Insurance:_____

Address:_____

Policy Number:_____ Group Number:_____

Policyholder Name and SS#:_____ Date of Birth:_____

Secondary Insurance:_____

Address:_____

Policy Number:_____ Group Number:_____

Policyholder Name:_____

Name, Address, & Telephone Number of Next of Kin:_____

I hereby understand that it is my responsibility for the bill for service rendered by Dr. Lentine. I also understand that if I have health insurance, that this is an agreement between my insurance company and myself. I understand that I am financially responsible for all charges whether or not covered by said insurance. If I belong to an HMO, it is my responsibility to notify my insurance that my primary physician is Dr. Nancy Lentine. It is also my responsibility to notify Dr. Lentine and staff of any insurance changes. I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received. In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account. If payments are not made on an outstanding account for 90 days or more, the account will be charged 15% interest. Appointments cancelled without 24 hours notice will be subject to a maximum charge of $100.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Blue Shield, HMO's and commercial insurance to Dr. Nancy Lentine. I hereby authorize said assignee to release any information to secure payment on my behalf.

****I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.**

Patient Signature:_____ Date:_____

Comprehensive History Questionnaire

Patient Name:_____Date:_____

Occupation_____
Reason for visit:

_____

_____

_____

List Current Health Problems for which you are being treated:_____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve you health over-all:
___diet ____fasting ____vitamins/minerals/herbs ____ chiropractic
___acupuncture ____ conventional drugs ____homeopathy ____other

Do you experience any of these symptoms EVERY DAY? Circle all that apply.

Debilitating fatigue	Panic Attacks	Vomiting	Chronic
Depression	Headaches	Diarrhea	pain/inflammation
Disinterested in sex	Dizziness	Constipation	Bleeding
Disinterested in eating	Insomnia	Fecal incontinence	Discharge
Shortness of Breath	Nausea	Low Grade fever	Itching/rash

Current Medication(prescription or over-the-counter) _____

_____

_____

Major Hospitalizations, Surgeries, injuries: List the date and WHY.

_____

_____

List all other physicians that you see and why:_____

_____

Do you have any allergies to medication? _____ If yes please list:_____

_____

Do you have food allergies?_____ If yes please list:_____

_____

Level of stress you are experiencing on a scale of 1 to 10(1 being the lowest)_____
Have you consider yourself underweight, overweight, just right? _____
Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months?_____
Is your job associated with potentially harmful chemicals or health +/or life threatening activities?_____
What are your current health goals? _____

_____

_____

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other _____

_____

Medical (Men)

- ☐ Benign prostatic hyperplasia (BPH)
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other _____

Age of first period _____

Date of last gynecological exam ____

Mammogram ☐ + ☐ –

PAP ☐ + ☐ –

Form of birth control _____

# of children _____

# of pregnancies _____

☐ C-section _____

- ☐ Surgical menopause
- ☐ Menopause

Date of last menstrual cycle _____

Length of cycle ____ days

Interval of time between cycles ____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

Health Habits

- ☐ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

- ☐ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

- ☐ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

☐ Water: #glasses/d _____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk
- ☐ Run, jog, jump rope
- ☐ Weight lift
- ☐ Swim
- ☐ Box
- ☐ Yoga

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ☐ Skip breakfast
- ☐ Two meals/day
- ☐ One meal/day
- ☐ Graze (small frequent meals)
- ☐ Food rotation
- ☐ Eat constantly whether hungry or not
- ☐ Generally eat on the run
- ☐ Add salt to food

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)
- ☐ Herbs - teas
- ☐ Herbs - extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other _____

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

MET427 7/00 Rev 1/03

Nancy Lentine DO
70 East Main Street
Little Falls, NJ 07424
973-237-0700

A. Notifier:

B. Patient Name:

C. Insurance: **D. ID Number:**

Financial Waiver of Non-coverage

Commercial Insurance

NOTE: If **C.** _____ doesn't pay for the following procedure or laboratory testing below, you may have to pay. Insurance providers do not pay for everything, even if you or your health care provider have good reason to think you need it. Your insurance may not pay for the procedure or testing below.

D. Procedure or Laboratory test	E. Reason for insurance Noncoverage	F. Estimated Cost of procedure
99381-99387-Preventive visits for new patients	Not a covered service	$150-$350
99391-99397- Preventative visits established patients	Not a covered service	$150-$350
99242-99245-Office Consultations	Not a covered service	$200-$450
99202-99205-Different types of initial office visits	Not a covered service	$10-$360
99211-99215-Different types of office visits	Not a covered service	$10-$360
88142-Obtaining of a cervical pap smear	Not a covered service	$100-$250
93922-Max Pulse	Not a covered service	$80-$150
93000-EKG	Not a covered service	$40
81003 - urine analysis	Not a covered service	$15
36415- venipuncture	Not a covered service	$10
96372- Injection	Not a covered service	$60
J3420- Vitamin B12	Not a covered service	$15
90471-90472-administration of Immunization	Not a covered service	$30
90715-dTap injection	Not a covered service	$60
86580-PPD skin test	Not a covered service	$20

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D. Procedure or Laboratory test	E. Reason for insurance Noncoverage	F. Estimated Cost of procedure
90662 or 90688-influenza vaccine	Not a covered service	$30
87880-Strep Screen	Not a covered service	$60
94640-inhalation treatment	Not a covered service	$45
J7626-inhalation treatment with Pulmocort	Not a covered service	$5

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the procedure or testing listed above.

G. Options: Check only one box. We cannot choose a box for you

_____Option 1. I want the testing listed above. I understand that if my insurance company doesn't pay, I am responsible for payment.

_____ Option 2. I want the procedures, testing and visits listed above, but do NOT bill my insurance. I will pay for all office charges.

_____Option 3. I do not want the procedures/testing listed above. I will not be seen at this office.

H. Additional Information:

I. Signature:	J. Date

Telehealth Consent Form

1. I authorize Nancy Lentine DO PA to allow me/the patient to participate in a telehealth (videoconferencing) service.

2. The type of service to be provided by via telehealth is: Family Medicine.

3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/ the patient's care and treatment which require physical tests or examinations may be conducted by providers and their staff at my/the patient's location under the direction of the telehealth healthcare provider.

4. My physician's staff has explained to me the nature and purpose of the videoconferencing and has also informed me of possible alternatives to the proposed sessions, including visits with a physician in- person. I have been given an opportunity to ask questions, and all my questions have been answered satisfactorily.

5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my healthcare provider or I can discontinue the telehealth service if we believe that the video conferencing connections are not adequate for the situation.

6. I understand that the telehealth session will not be audio or video recorded at any time.

7. It is the responsibility of the telehealth provider to conclude the service upon termination of the videoconference connection.

8. I the patient understand that my insurance will be billed by the local healthcare provider for telehealth services. I understand that if my insurance does not cover telehealth services, I the patient will be billed directly by the local healthcare provider for the provision of telehealth services. I understand and agree that if my insurance company does not pay for such services that I would be responsible for payment

9. I consent to participate in this telehealth service which shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.

10. I agree that there have been no guarantees or assurances made about the results of this service.

11. I the patient acknowledge the telehealth program's no-show policy which states that I will be discharged from the telehealth program if I "no- show" for two, consecutive telehealth appointments, without prior contact to the scheduling staff at spoke site. I also understand that I will be billed for the "no show" appointment.

_____

Patient/Relative/Guardian Signature* Relationship to Patient (if required)

_____ _____

Print Name **Date**

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Provider's Signature **Date**

To: ALL PATIENTS
From: Dr. Nancy Lentine

Dear Patients,

Please note that due to our practice recently increasing in size, we must institute certain policies so that the office can function at the utmost efficiency and to continue our mission to be able to provide premium healthcare for all our patients. We hope that you understand the need to do so.

Thank you.

2020 Updated Office Policies for Dr. Nancy Lentine

1. The amounts of incoming calls for normal results are becoming a burden to the practice. We will call patients with abnormal labs- no need for patients to call. Any results will be discussed at your next visit/phone consult. Any results that need to be addressed prior to your appointment will receive a phone call or letter. If you need copies of labs, they can be provided at the next visit.
2. Blood work must be done every 4-8 months depending on the medications that you are on. There may be no refills on medications until these results are received. Please make sure that you have an updated blood work order prior to leaving the office or hanging up from a phone consult.
3. If refills are not requested at the time of your visit, there will be a **$5.00 charge** for each prescription that needs to be called in or mailed.
4. Please bring a complete list of medications, supplements/vitamins to each visit.
5. Please bring a brief list of best/worse symptoms to every visit.
6. When calling and leaving voicemail messages, please leave a detailed message including: first and last name, telephone number, and specific details of the problem or question. This makes it easier for the nurse or office staff to have an answer from the provider when they return your call. Please, also, speak clearly and slowly when leaving the message.
7. If your medication needs prior-authorization, please do not continually call the office. We will call you or your pharmacy with the insurance company's decision. This may take up to 2 weeks. IV therapy can also take up to 2 weeks (or longer) to set up – depending on your insurance company. If a medication prescribed is denied, we request that you contact the insurer to find out the reason for the denial and preferred medication alternatives. The number that you would need to call to contact your insurance will either be on the back of your card or can be given to you by your pharmacy.
8. Brief phone calls for questions will not be charged as a phone consult. However, due to limited time constraints and high call volume, if a provider or nurse is kept on the phone for a prolonged amount of time (i.e. 10 minutes or longer) or receives multiple phone calls within a week you may be billed for their services and it is an **out-of-pocket expense**.
9. Be sure to schedule a follow up appointment BEFORE leaving the office or call ASAP. The schedules book up quickly and you may not be able to be accommodated unless you follow this procedure.
10. If you are calling the office for multiple supplements, be sure you give the receptionist a complete list of what you need. Take inventory of your supplements prior to calling or email a list to FamilyPractice96@gmail.com.
11. If you are going to other doctor's appointments and need lab results or records sent to them, 48 hour notice must be given unless it is an emergency appointment.
12. There will be no charge for the most recent labs or progress notes to be copied. If you require this, please ask your provider during the visit. Other copies may be charged a minimum fee due to the overwhelming demand by patients for copies which burden's the medical records department.
13. If you need a medical clearance before your surgery, please call and schedule an appointment 10-14 days before your surgery so that everything can be ready on the day of the your surgery.

_____ _____

Signature Date