**Medical Diagnostic Associates, P.A**.

*Carol G. Simon Cancer Center at Overlook Hospital*

99 Beauvoir Ave, Summit, NJ 07901
Phone (908) 608-0078 Fax (908) 608- 1504

**Dennis A. Lowenthal, M.D., Daniel J. Moriarty, M.D., Bonnie L. Guerin, M.D., Neil Morganstein, M.D., Sophie D. Morse, M.D.**

Dear:_____
You have a Consultation with Dr. _____
This appointment has been scheduled for _____
_____**Arrival Time (30 minutes prior to your appointment time)**
_____**Appointment Time**

Please read and complete this packet in its entirety. There are some pages that require information on both sides. Also, please provide our office with the name, address, and telephone number of all physicians participating in your care. Be sure to include your primary care physician, referring physician, OB/GYN, cardiologist, etc. Also, you will need to provide a medication list. Please include dosage and frequency of how you take your medications.

**We must have all medical records faxed pertaining to your appointment prior to the scheduled date of your appointment.** Please fax all records to **908-608-1504** to the Attention to: NEW PATIENT COORDINATOR. If your records originate from Overlook Hospital, we are able to obtain those medical records for your appointment. When gathering your medical records, please include the following if it pertains to your appointment:

- **Blood work** (we would like a three year history)
- **Radiology Reports,** CAT Scan, PET Scan, or MRI Reports, X-RAY and BONE SCANS
- **Mammography Reports** (any and all Mammograms including the Bilateral Mammography and Ultrasound prior to any diagnosis)
- **Pathology** (any and all biopsy and surgery pathology reports)
- **Operative Reports** (any and all transcriptions involving the diagnosis)

In addition, we ask that you arrive **30 minutes prior** to your scheduled appointment time. If referrals are required, please have it at the time of your first appointment. If your physician has given you a prescription referring our physician, ***please bring it with you to the appointment***.

Regarding co-pays, if the insurance requires you to pay the co-pay for a specialist, we will be collecting it at your initial visit. This will occur every time you come for a visit with your Doctor at our office thereafter. This is part of our agreement with your insurance company and is considered part of the amount we have contracted with them to accept as payment. If you have any questions regarding your co-pay, please contact your insurance company for further clarification.

Make checks payable to **PRACTICE ASSOCIATES MEDICAL GROUP**.
Thank you for your time and attention,
Medical Diagnostic Associates, P.A.

Medical Diagnostic Associates
99 Beauvoir Avenue
Summit, NJ 07902
908-608-0078
908-608-1504 – Fax

Directions:

Route 24 West:
Take exit marked Millburn. Springfield. Summit. Bear right to Broad Street and follow blue hospital signs uphill to Hospital.

Route 24 East:
Take Summit Avenue Exit. Follow Summit Avenue through downtown Summit, over Railroad Bridge and through traffic light at Broad Street. Make second left at Walnut Street and follow blue Hospital signs.

From Due North or Northwest:
Take Kennedy Parkway to Short Hills Mall. Take either Route 24 East or Route 124 East (access road). Get off Summit Avenue Exit (1/2 mile). Take Summit Avenue through downtown Summit and follow blue Hospital signs.

Garden State Parkway South:
Take Exit 142 to I-78 West to Route 24 West. Then follow directions from Route 24 West (above).

Garden State Parkway North:
Take Exit 142. You must take the Exit immediately after the toll plaza (stay to the extreme right at the toll plaza). Proceed one mile East on I-78 before following signs to make U-turn to I-78 West. Take I-78 West to Route 24 West (stay in right lane). Then follow directions from Route 24 West (above).

I-78 East:
Take Exit 45, marked Summit-Glenside Avenue. Make a left at traffic light at end of ramp onto Glenside Avenue. Follow Glenside for two miles to blue Hospital sign. Then take a left onto Baltusrol Road and then a sharp left onto Morris Avenue at next blue Hospital sign.

I-78 West:
Take Exit 49 to route 24 West. Then follow directions from Route 24 West (above).

New Jersey Turnpike North or South:
Take Exit 14, marked Newark Airport to I-78 West. Follow nine miles to Route 24 West (stay in right lane). Then follow directions from Route 24 West (above).

Route 22:
You must be in the westbound lane for Summit Road Exit on Route 22 in Mountainside. Turn right at Getty stations for Summit Road, which becomes Baltusrol Road. Follow blue hospital signs, turning left up Morris Avenue. Pass Overlook Hospital and take next right at Beauvoir Place (just before traffic light). Bear right uphill to Hospital.

**Park in the visitors parking garage. Come through the Cancer Center doors and make an immediate left through the sliding glass doors and the office will be on your right.**

**WELCOME TO OUR OFFICE**
***MEDICAL DIAGNOSTIC ASSOCIATES***

NAME:_____ D.O.B:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PRIMARY PHONE #_____ SECONDARY PHONE # _____

EMAIL ADDRESS:_____SOCIAL SECURITY # _____

RACE: _____ PRIMARY LANGUAGE: _____ ETHNICITY: _____

OCCUPATION: _____ EMPLOYER: _____

NAME OF SPOUSE: _____ D.O.B: _____

**YOUR CARE TEAM:**

| | NAME | ADDRESS | PHONE # | FAX # |
|---|---|---|---|---|
| **REFERRING MD** | | | | |
| **OB/GYN** | | | | |
| **PRIMARY CARE PHYSICIAN** | | | | |
| **CARDIOLOGY** | | | | |
| **OTHER** | | | | |
| **OTHER** | | | | |

***PHARMACY***

NAME:_____

ADDRESS: _____

PHONE NUMBER: _____

***EMERGENCY CONTACTS:***

NAME: _____ NAME: _____

PHONE #: _____ PHONE #: _____

RELATIONSHIP: _____ RELATIONSHIP: _____

**Medical Diagnostic Associates, P.A.**

# Health History

**(Confidential)**

**Name**_____ **Birth date**_____ **Age**_____

**Reason for Visit**_____ **Date**_____

**Symptoms:** Check (√) symptoms you are currently experiencing

**General:**
- ☐ Chills
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Sweats
- ☐ Fatigue

**Eyes:**
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Tearing
- ☐ Red Eyes

**Ears/ Nose/ Throat:**
- ☐ Hoarseness
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Hearing Loss

**Cardiovascular:**
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swelling of Legs

**Respiratory:**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing Blood

**Gastrointestinal:**
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Bowel Changes
- ☐ Vomiting Blood
- ☐ Rectal Bleeding
- ☐ Bloating
- ☐ Hemorrhoids

**Genitourinary:**
- ☐ Blood in Urine
- ☐ Frequent Urine
- ☐ Painful Urination
- ☐ Incontinence
- ☐ Urinating at Night

**Mental Health:**
- ☐ Loss of Sleep
- ☐ Anxiety
- ☐ Depression
- ☐ Stress

**Neurologic:**
- ☐ Headaches
- ☐ Seizures
- ☐ Fainting
- ☐ Numbness
- ☐ Tremors

**Musculoskeletal:**
**Pain in:**
- ☐ Back
- ☐ Arms
- ☐ Legs
- ☐ Hands

**Skin:**
- ☐ Easy Bruising
- ☐ Itching
- ☐ Change in Moles
- ☐ Hives

**Men Only:**
- ☐ Breast Lump
- ☐ Erectile Difficulty
- ☐ Lump in Testicle
- ☐ Penis Discharge

**Women Only:**
- ☐ Abnormal Pap Smear
- ☐ Breast Lump
- ☐ Irregular Periods
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Number of pregnancies ____

**Health Maintenance:**
Date of last colonoscopy_____
Date of last Pap Smear_____
Date of last mammogram ____
Date of last PSA ____

**CONDITIONS:** Check (√) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Coronary Disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraines
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problem
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Other

| **FAMILY HISTORY:** Fill in information about your family | | | | | | |
|---|---|---|---|---|---|---|
| **Relation** | **Age** | **State of Health** | **Cause of Death** | | **Check if your blood relatives had: Disease** | **Relationship** |
| Father | | | | | Cancer | |
| Mother | | | | | Diabetes | |
| Brothers | | | | | High Blood Pressure | |
| | | | | | Heart Attacks | |
| | | | | | Strokes | |
| Sisters | | | | | Kidney Disease | |
| | | | | | Blood Clots | |
| | | | | | | |
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| **HOSPITALIZATIONS/ SERIOUS ILLNESS** | | |
|---|---|---|
| **Year** | **Hospital** | **Reason for Hospitalization/ Illness** |
| | | |
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| | | |

**Have you ever had a blood transfusion?** ☐ Yes ☐ No Did you have a reaction_____
If Yes give approximate dates: _____

| **SOCIAL HISTORY** | | | | | **Pregnancy History** | | |
|---|---|---|---|---|---|---|---|
| | Current | Packs/drinks | Past | Packs/drink | Year of Birth | Sex | Complications |
| Tobacco | | | | | | | |
| Alcohol | | | | | | | |
| If you have quit smoking/ drinking how many years has it been? _____ | | | | | | | |
| Occupation:_____ | | | | | Have you had a miscarriage? If yes, how many_____ | | |

I certify that he above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature: _____ Date: _____

Reviewed By: _____ Date: _____

QD-Daily
BID- Twice
TID- Three
QOD- Every Other

Medical Diagnostic Associates, P.A.
*Carol G. Simon Cancer Center*
99 Beauvoir Ave. Summit, NJ 07902
(P) 908-608-0078 (F) 906-608-1504

Date of Office Visit

| R | MEDICATION | MG | DOSE | | | | | | | | | | | |
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Patient _____ D.O.B _____ Chart # _____

**MEDICAL DIAGNOSTIC ASSOCIATES, P.A.**

ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE
AND
DESIGNATION OF DISCLOSURE

**Acknowledgment of Privacy Practice Notice**

I have received a copy of the Medical Diagnostic Associates Notice of Privacy Practices.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient/Parent/Guardian Date

**Designation of Certain Relatives, Close Friends and Other Caregivers**

I agree that Medical Diagnostic Associates may disclose my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Medical Diagnostic Associates will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Medical Diagnostic Associates' making the limited disclosure described above. I understand that I am not required to list anyone. I also understand that I may change this list in writing at any time.

_____ Date of Birth: _____
*Print Name*

_____ Date of Birth: _____
*Print Name*

_____ Date of Birth: _____
*Print Name*

_____ Date: _____
*Signature of Patient/Parent/Guardian*