WMC Health | Bon Secours Medical Group
Westchester Medical Center Health Network

Welcome To Mahwah Medical

We hope that the following information will be helpful in making your visit and needed information easy to obtain.

We are located at:

10 Franklin Turnpike
Mahwah, NJ 07430

Our Telephone number is (201) 529-0033, phones are on:

Monday	9:00 AM - 5:45 PM
Tuesday	9:00 AM - 4:45 PM
Wednesday	9:00 AM - 5:45 PM
Thursday	9:00 AM - 4:45 PM
Friday	9:00 AM - 4:45 PM
Sat & Sun	9:00 AM- 2:45 PM * Due to covid we are closed at this time

Our office Hours are

Monday	8:30 AM- 6:00 PM
Tuesday	8:30 AM-5:00 PM
Wednesday	8:30 AM-6:00 PM
Thursday	8:30 AM-5:00 PM
Friday	8:30 AM-5:00 PM
Sat & Sun	9:00 AM- 3:00 PM *

Appointments are preferred on weekdays.
Walk-ins for same day appointments are available

We will do our best to give you the provider you request with a priority for annual and follow up visits. In some cases, especially when you need same day care, you may be offered an appointment with another provider.

Our doctors are on call 24 hours a day for urgent problems after hours. Please call (201) 529-0033; our answering service will connect you with the on call provider

Please arrive 15 minutes early for registration.

For your convenience we have enclosed the following forms to be completed by you, before your scheduled appointment: **Registration form, Patient Medication Record and Special Authorization Forms.** The **Special Authorization Form** is used to share information in your medical chart with other physicians and family members.
(If returning by mail please allow at least five business days before your appointment)

On the day of your appointment, please make sure that you bring your insurance card, photo ID and referrals if needed. You will also need to bring your actual chest x-ray/Cat Scan films if you have a pulmonary consult scheduled.

If you have any questions regarding the transfer of records to our practice please contact us at (201) 529-0033

Mahwah Medical

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Registration

Last Name_____ First Name_____ MI _____

D.O.B _____/_____/_____ Sex: ☐ Male ☐ Female SSN: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Other Pacific Islander

Ethnicity ☐ Hispanic ☐ Non-Hispanic Language _____

Mailing Address_____

Home Phone _____ Mobile Phone_____

Email Address_____@_____ ☐ None ☐ Decline

Employed ☐ Employer_____Occupation_____

Student ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disabled

Emergency Contact: _____Relationship_____

Emergency Phone: _____

Who referred you to us? _____

Please check as they apply to you. If you have any questions please speak with your Provider.

Do you have? ☐ **Health Care Proxy** ☐ **Advanced Directive** ☐ **Durable Power of Attorney**

Can you provide a copy ☐ Yes ☐ No

Name of Legal Guardian or Health care proxy_____

Relationship to patient: _____Phone: _____

Primary caregiver: provides day to day care for patient and receives instructions about care ☐ None ☐ Yes

Caregiver Name_____

Relationship to patient _____

Turn over to continue on back page

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Name: _____ DOB: _____ Date: _____

Patient Health Questionnaire (PHQ-9)

Over the **last 2 weeks** how often have you been bothered by any of the following problems?
Please circle a number to indicate your answer.

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleep too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspapers or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For Office: _____ + _____ + _____ + _____ = _____

***If you checked off **any** problems, how **difficult** have these problems made it for you to do you work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

CAGE-AID Questionnaire

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	Yes	No
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

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Date: _____

Print Name: _____ DOB: _____/_____/_____

List of Physicians and Consultants You are Seeing

Consultant	Name (S)
Cardiology (Heart)	
Pulmonary (Lungs)	
Gastroenterology (Stomach)	
Nephrology (Kidney)	
Neurology (Brain)	
Endocrinology (Diabetes-Thyroid)	
Oncology (Cancer)	
Gynecology (Women)	
Urology (Prostate-Urinary)	
Dermatology (Skin)	
ENT (Ear,Nose,Throat,Allergy)	
Surgeon	
Ophthalmology (Optometry-Eye Doctor)	
Podiatry (Foot)	
Other	

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Date: _____

Patient Name: _____ **DOB :** _____

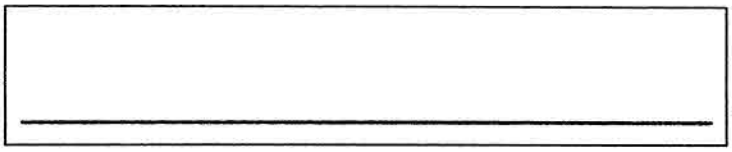
Health Maintenance Checklist

TEST	DATE	PLACE/DOCTOR
Mammogram Women 40yo and older annual		
Colorectal Cancer Screening (Please circle) Colonoscopy Sigmoidoscopy Stool testing – Please indicate which one. Age 50 and older. Repeat interval determined by provider		
Bone Density Women age 65yo Repeat interval determined by provider		
Pap smear Women 21-65yo every 3 years (or interval per GYN)		
Eye Exam Diabetics annual Glaucoma screen		
Recent Immunizations	Flu: Pneumococcal: Prevnar: Shingles: Shingrix: Tetanus: Tdap:	
Living Will or Advanced Directive		**If you have one please bring a copy to your visit**

Bon Secours Medical Group
CONSENT TO TREAT FORM

I request that payment of authorized insurance benefits, including Medicare, If I am a Medicare beneficiary , be made on my behalf to Bon Secours Medical Group for any services provided to me by Bon Secours Medical Group. I understand that Bon Secours Medical Group has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Bon Secours Medical Group, I agree to forward the practice all health insurance and other third –party payments I receive for services rendered to me immediately upon receipt. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I hereby authorize Bon Secours Medical Group to administer medications and immunizations and to perform diagnostic procedures as may be necessary for proper health care to myself and / or my child.



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and the faculties listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

MAHWAH MEDICAL
10 Franklin Turnpike
Mahwah, NJ 07430
(201) 529-0033

Patient Financial Responsibility

It is for your best interest to understand your insurance.

At registration time, we will need to obtain a copy of your driver's license and a current valid insurance card. If you fail to provide us with the correct insurance or any insurance information in a timely manner, you may be responsible for the balance of the claim. Most insurance companies have timely filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and it will become your responsibility.
Also, always be sure to know your coverage, for example; some vaccines, labs, procedures, etc. may not be covered under your plan, it is always good to know also what lab you can use, otherwise you will be responsible at the end.

I acknowledge and understand that it is ultimately my responsibility and my obligation to check all requirements, coverages, deductibles, co-pays with my insurance.

PRINT - LAST NAME FIRST NAME DOB:

Signature of Patient or Legal Guardian

Today's date

Health History Questionnaire (age 10 and up)

Manwan Medical

Patient Name: _____ **DOB:** _____

Reason for today's visit:

_____.

Personal Medical Problems ☐ None known

_____

_____

_____

Have you ever been treated for depression, anxiety or any other mental health problem? Yes ☐ No ☐

Surgeries: ☐ None

Type of Surgery & Date: _____ Type of Surgery & Date: _____.
Type of Surgery & Date: _____ Type of Surgery & Date: _____.
Type of Surgery & Date: _____ Type of Surgery & Date: _____.

Non-surgical hospitalizations: (please include Date and Hospital): ☐ None

_____.
_____.
_____.

Medications: (list all medications, including Over the Counter) – include Dose and Frequency ☐ None

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Pharmacy Name: _____ **Phone number:** _____

Allergies: (include reaction): ☐ none known

_____

_____

Social History:

Tobacco use: Yes ☐ No ☐ Cigarettes or Pipe _____ packs/day for _____ years. ☐Quit Date: _____
Smokeless Tobacco use: Yes ☐ No ☐ _____ packs/cans per day for _____ years. ☐Quit Date: _____
Alcohol use: How many drinks per day? _____ Week? _____ Month? _____
What kind of Alcohol? Beer, Wine, Liquor

Have you ever or do you now use illegal drugs? Yes ☐ No ☐ Which? _____

Exercise: ☐ No Exercise ☐ Mild Exercise ☐ Occasional, less than 4x/week ☐ Regular vigorous
Caffeine: ☐ None _____ cups/cans per day
Are you currently trying to lose weight? Yes ☐ No ☐ Are you happy with your weight? Yes ☐ No ☐

Women Only:

Age at onset of menstruation: _____ Date of last menstrual period: _____

Pregnancies: _____ # Live births: _____ # Living children _____
Miscarriages/Abortions: _____ # Vaginal births: _____ # C-sections: _____

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Practice Communication and Personal Health Information (PHI) Form

By completing this form you will be granting Bon Secours Medical Group permission to release your Protected Health Information (PHI) to one or more personal representatives and/or to communicate with you in certain ways. Only the information indicated below will be released to your personal representative and/or communicated to you in the manner specified. This authorization is valid for one year from the date signed and will be renewed by the practice on a yearly basis. If at any time you would like to modify or revoke this permission you may do so by contacting the practice.

Patient Name: _____ Patient DOB: _____

Home Phone_____ Mobile Phone _____ Work Phone _____

Patient Address: _____

I request and authorize Bon Secours Medical Group to disclose and/or release my protected health information (PHI) to:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____

This authorization applies to :(check all that apply)

___ Healthcare Information

___ Demographic Information

___ Mental Health Information

___ HIV Information

___ Alcohol/Drug Treatment Information

___ Financial Information

___ Other Information Please Specify

_____

_____

_____

I hereby authorize Bon Secours Medical Group to:

Leave a message on my [ ] home [ ] business [ ] cellular telephone answering machine/voicemail, this message may contain my protected health information (PHI).

I also authorized Bon Secours Medical Group to contact _____ at the following number _____ in case of an emergency or to contact me regarding urgent medical issues.

I have carefully read and understand the above authorization. This authorization applies to all medical offices within the Bon Secours Medical Group, unless otherwise specified. I also understand that this authorization may be revoked at any time by contacting the practice administrator.

Printed Patient Name: _____

Patient Signature: _____

Authorization Date: _____ Expiration Date: _____
(One year after authorization date)

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Advance Care Planning Questionnaire

Advance Care Planning: What is it? Advance Care Planning is a process of planning for future medical care in case you are unable to make your own decisions. It lets you authorize someone you trust to make your health decisions if or when you can't.

Last Name: _____ First Name: _____

DOB _____/_____/_____ Date: _____/_____/_____

Please check as they apply to you. If you have any questions please speak with your Provider.

Do you have? ☐ **Health Care Proxy** ☐ **Durable Power of Attorney** ☐ **Advanced Directive** ☐ **Do Not Resuscitate**

☐ Other: _____

Can you provide a copy? ☐ Yes ☐ No

Who have you appointed to make medical decisions for you? (Primary Health Care Decision Maker)

Name: _____

Phone Number: _____

Address: _____

_____.

Relationship to patient: ☐ Spouse ☐ Parent ☐ Sibling ☐ Adult child ☐ Friend

☐ Guardian ☐ Friend ☐ Life Partner ☐ Other Relative _____

Have you appointed an additional person to make medical decisions for you? (First Alternate Health Care Agent)

Name: _____

Phone Number: _____

Address: _____

_____.

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Sibling ☐ Adult child ☐ Friend

☐ Guardian ☐ Friend ☐ Life Partner ☐ Other Relative _____

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A Member of the Westchester Medical Center Health Network

10 Franklin Turnpike • Mahwah, NJ 07430
Phone: 201-529-0033 • **Fax:** 201-529-5913

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize (provider) _____ to disclose information/health records:

Patient name: _____ Date of Birth: _____

Address: _____ Phone: _____

Tests:

	Mammogram (Yearly for females age 40 & older)
	Dexa- Bone Density (Every 2 yrs. for females 65 & older)
	Pap smear (Women age 21-65 every 3 yrs or as indicated by your GYN)
	Eye Exam (If you are Diabetic yearly dilated eye exam)
	COLONOSCOPY/COLOGUARD (Due at age 50 & repeat every 10 years Or as indicated by your GI) For Cologuard please speak to your physician)

This information is to be disclosed to:

Doctor or Clinic: _____

Address: _____

Phone: _____ Fax: _____

For the purpose of: _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date or condition: _____

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein.

Signed (Patient): _____ Date: _____

Or legal representative: _____ Relationship to patient: _____