Holy Name Primary Care and Specialty Associates, P.C.

751 Teaneck Road
Teaneck, NJ 07666
Tel (201) 837-3200 * Fax (201) 837-8993

Peter W. Coppola, M. D.D.-A.B.I.M.
Michael Denker, M. D.
Judith Kutzleb, D.N.P.

Name: ____

Address: ____

City: ________________________________State: __________Zip code: ____________

Home telephone #: ______________________Cell Phone#:_________________________

Date of Birth: ________________________ Sex:________ Marital Status:_______________

Email: ____

Social Security #: ____

Employer: _________________________ Employer Telephone #: ____________________

Contact in case of emergency: ________________________ Telephone #:____________ Relation: __________

Referred by: ____

Allergies: ____
(If none, please write out “No Known allergies”)

Pharmacy Name and Phone Number: ____

Do you currently have a living will? ____

Insurance Information

	Primary	Secondary
Company:	____________________	____________________
ID #:	____________________	____________________
Name of Insured:	____________________	____________________
Employer:	____________________	____________________

******NECESSARY INFORMATION********

I hereby authorize that payment of authorized insurance (eg, Medicare & Medigap) benefits be made either to me or on my behalf to Holy Name Primary Care and Specialty Associates, P.C. for any services furnished to me by Holy Name Primary Care and Specialty Associates, P.C. I authorize Holy Name Primary Care and Specialty Associates, P.C. to release information regarding services rendered by them to my insurance carriers and allow a photocopy of my signature to be used to file insurance.

Signature: _________________________________ Date:____________________

PFSH

Patient Name: ______________________________ Date of Birth: ______________

Drug Allergies/Sensitivities: ______________________________

____

Medical History:

Do you now, or have you in the past had any of the following.
If your answer is "Yes" to a question, please make comments on the following line and indicate date/year diagnosed.

Condition	Yes/No	Comments
Asthma………………..	❒Yes❒No	____________
COPD………………	❒Yes❒No	____________
Coronary Artery Disease	❒Yes❒No	____________
Congestive Heart Failure	❒Yes❒No	____________
Cancer…………………	❒Yes❒No	____________
Heart Attack…………	❒Yes❒No	____________
High Blood Pressure.........	❒Yes❒No	____________
Elevated Cholesterol….....	❒Yes❒No	____________
Implantable Devices……	❒Yes❒No	____________
Liver Disease……….....	❒Yes❒No	____________
Kidney Disease………...	❒Yes❒No	____________
Diabetes………………..	❒Yes❒No	____________
Incontinence of Urine…	❒Yes❒No	____________
Irritable Bowel Syndrome	❒Yes❒No	____________
Reflux (GERD)…………	❒Yes❒No	____________
Thyroid Disease............	❒Yes❒No	____________
Other...............................	❒Yes❒No	____________
Stroke.............................	❒Yes❒No	____________
Arthritis............................	❒Yes❒No	____________
Osteoporosis......................	❒Yes❒No	____________
Rheumatoid Arthritis........	❒Yes❒No	____________
Back or Neck Pain...........	❒Yes❒No	____________
Skin Problems................	❒Yes❒No	____________
Anemia...........................	❒Yes❒No	____________
Blood Disorder..............	❒Yes❒No	____________
STDs..............................	❒Yes❒No	____________
HIV or AIDs....................	❒Yes❒No	____________
C-difficile.......................	❒Yes❒No	____________
MRSA...........................	❒Yes❒No	____________
Tuberculosis.....................	❒Yes❒No	____________
Depression........................	❒Yes❒No	____________
Anxiety.............................	❒Yes❒No	____________
Eating Disorder................	❒Yes❒No	____________
Seizures.........................	❒Yes❒No	____________

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____

Surgical History

If your answer is "Yes" to a question, please make comments on the following line and indicate date/year of the surgery.

Surgery	Yes/No	Comments
Appendectomy.............	❒Yes❒No	____________
Breast Biopsy................	❒Yes❒No	____________
Cholecystectomy..........	❒Yes❒No	____________
Coronary Artery By-Pass	❒Yes❒No	____________
Hernia..........................	❒Yes❒No	____________
Hip Replacement...........	❒Yes❒No	____________
Hysterectomy..................	❒Yes❒No	____________
Knee Replacement.........	❒Yes❒No	____________
Eye Surgery....................	❒Yes❒No	____________
Other..............................	❒Yes❒No	____________

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____

Specialist(s):

Please list all doctors, their specialty and office information who provided and/or currently providing care to you.

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Family History

Condition	Y/N	Mother	Age of Onset	Father	Age of Onset	Grand-Father	Age of Onset	Grand-Mother	Age of Onset	Grand-Father	Age of Onset	Grand-Mother	Age of Onset	Sister	Brother
Aneurysms........	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Breast CA.........	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Colo-Rectal CA	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Ovarian CA........	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Pancreatic CA.....	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Other CA...........	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
____________________															
Diabetes.......	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Alcohol Depend..	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Drug abuse.........	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Heart Disease......	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Hypertension......	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
High cholesterol.	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Stroke.................	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Mental Illness....	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐
Other	❐Y❐N	❐	________	❐	________	❐	________	❐	________	❐	________	❐	________	❐	❐

Mother
☐ Alive, Age ____
☐ Deceased, Age ____ of ___________

Father
☐ Alive, Age ____
☐ Deceased, Age ____ of ________

Sister(s)
☐ Alive, Age ____
☐ Deceased, Age ___ of ____________
☐ Alive, Age ____
☐ Deceased, Age ___ of ____________
☐ Others

Brother(s)
☐ Alive, Age ____
☐ Deceased, Age ____ of _________
☐ Alive, Age ____
☐ Deceased, Age ___ of __________
☐ Others

Social History

Tobacco
☐ No
☐ Yes ______ppd ______years
☐ Quit date_________________

Stage
☐ Precontemplation
☐ Contemplation
☐ Action
☐ Consolidation
☐ Relapse

ALCOHOL
☐ No
☐ Yes ____Social ____Daily use

Marital Status
☐ Single
☐ Married
☐ Civil Union
☐ Divorced
☐ Widow(er)

Children
☐ Boy(s) Age(s) __________________
☐ Girl(s) Age(s) __________________

Occupation(s)
____

Religious Preference
____

Level of Activity (Exercise) ☐ None ☐ Occasional ☐ Regular ☐ Vigorous

Illicit Drug Use ☐ No ☐ Yes Types/Quantity/Frequency_____________________
____

Patient Signature: ____ Date: ____________________________

Reviewed by: ☐ Peter W. Coppola, MD ☐ Michael Denker, MD ☐ Judith Kutzleb, APN

Signature: _________________________ ___________________________ Initial review date: ___________________________