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

Peter W. Coppola, M. D.
Michael Denker, M. D.
Judith Kutzleb, D.N.P.
Phone: (201) 837-3200

751 Teaneck Road
Teaneck, NJ 07666

Fax: (201) 837-8993

ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Holy Name Primary Care and Specialty, P.C.

Print Patient Name:_____

Signature of Patient: _____*

Date:_____

*If person signing is not the patient, please print your name and relationship to patient:
Name _____

Relationship _____

I [patient or representative] request a copy of the Notice of Privacy Practices: Yes _____ No _____

You have my permission to discuss my medical condition with the following person or persons:

_____

_____

For Office Use:

If patient/representative requested copy of Notice, date copy was provided: _____.

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment: _____

_____

_____

_____

_____

_____

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********Required Laboratory _____

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.

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_____

_____
_____
_____
_____

Surgical History

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

Appendectomy..... ❒Yes❒No_____
Breast Biopsy..... ❒Yes❒No_____
Cholecystectomy..... ❒Yes❒No_____
Coronary Artery Bypass.. ❒Yes❒No_____
Hernia..... ❒Yes❒No_____
Hip Replacement..... ❒Yes❒No_____
Hysterectomy..... ❒Yes❒No_____
Knee Replacement..... ❒Yes❒No_____
Eye Surgery..... ❒Yes❒No_____
Other..... ❒Yes❒No_____

_____
_____
_____
_____

Specialist(s):

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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Family History

		Parent		Parent		Maternal		Maternal		Paternal		Paternal		Siblings	
		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_____