3322 Route 22, Suite 605
Branchburg, NJ 08876
Phone: (908) 428-7530
Fax: (908) 428-7529

Louis J. Arno MD, FACP, FCCP

Pulmonology • Critical Care

Dear Patient,

Welcome to THE OFFICE OF DR. LOUIS ARNO! We are sending you our Patient Information, History, Medication, and HIPPA Privacy forms for you to fill out before your office visit. **DUE TO HIGH VOLUME, YOUR APPOINTMENT MAY BE EFFECTED IF THIS PAPERWORK IS NOT COMPLETE WHEN YOU ARRIVE FOR YOUR OFFICE VISIT.**

Be sure to bring these COMPLETED FORMS with you for your visit, as well as the following:

- YOUR INSURANCE CARD(S)
- DRIVER'S LICENSE
- REFERRAL (IF REQUIRED)
- RECENT CAT SCAN, X-RAY FILMS, LAB REPORTS; REPORTS ARE THE RESPONSIBILITY OF THE PATIENT – FILMS AND REPORTS MUST BE BROUGHT FOR THIS APPOINTMENT.

In addition, it is very important that you arrive at least ***15 MINUTES*** prior to your appointment time to allow our staff to update your patient records.

For your convenience, we have also enclosed directions to our office.

Sincerely,

Dr. Arno's Staff

Appointment Schedule For:

Date:_____

Time:_____

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DIRECTIONS

Via 1-287 South: Exit 14 B Route 22 West. Travel West on 22W approximately 10-15 miles. You will see a sign for Urgent Care on your right...our entrance is the right turn into Branchburg Commons. Turn left at second driveway and you will see our Suite 605 on the left.

Via 1-287 North: Exit 14 A Route 22 West. Travel West on 22W approximately 10-15 miles. You will see a sign for Urgent Care on your right...our entrance is the right turn into Branchburg Commons. Turn left at second driveway and you will see our office Suite 605 on the left.

Via Route 22 West: Travel West on 22W. Pass the Branchburg Shoprite, go through the next traffic light and then you will see a sign for Urgent Care on your right...our entrance is the right turn into Branchburg Commons. Turn left at second driveway and you will see our office Suite 605 on the left.

Via Route 22 East: Travel East on 22E. Make a right turn off 22E at the Readington Road exit, you will see the Branchburg Shoprite ahead of you; stay to the left and turn left at the light. Again, stay to the right, pass the next light, staying on the right you will see a sign for Urgent Care...our entrance is the right turn into Branchburg Commons. Turn left at the second driveway and you will see our office Suite 605 on the left.

Louis J Arno MD
3322 Route 22
Suite 605
Branchburg, NJ 08876
USA
(908) 428-7530

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)	ETHNICITY

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	SECONDARY HOME PHONE	RACE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	SECONDARY HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	SSN# / BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN

DATE

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Patient:_____ Date of Birth:_____/_____/_____

Home Phone: ( ) _____- _____ Work/Cell Phone ( ) _____-_____

Name of Pharmacy:_____Pharmacy: ( ) _____-_____

MEDICATIONS

MEDICATION	DOSAGE	FREQUENCCY (How often do you take it?)

Allergies:_____

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Date: _____ **Patient Name:** _____

Reason for visit: _____

Please take a few minutes to complete the following questions about symptoms you may be Having. This will become part of your permanent medical record. Thank you!

System Review	Questions-Do you have the following?	No	Yes	Comments
Constitutional	Fever	( )	( )	_____
	Loss of Appetite	( )	( )	_____
	Weakness	( )	( )	_____
	Weight gain or loss	( )	( )	_____
Eyes	Blurred Vision	( )	( )	_____
	Double Vision	( )	( )	_____
Ear, Nose, Throat	Hoarseness	( )	( )	_____
	Nosebleeds	( )	( )	_____
Cardiovascular	Chest Pain	( )	( )	_____
	Difficulty climbing stairs	( )	( )	_____
	Dizziness	( )	( )	_____
	Leg swelling	( )	( )	_____
	Pain in the legs when walking	( )	( )	_____
	Palpitations	( )	( )	_____
	Passing out spells	( )	( )	_____
	Shortness of breath	( )	( )	_____
Respiratory	Asthma/Wheezing	( )	( )	_____
	Cough with or without phlegm	( )	( )	_____
	Shortness of breath while walking	( )	( )	_____
	Spitting up blood	( )	( )	_____
Gastrointestinal	Blood in stool	( )	( )	_____
	Constipation/Diarrhea	( )	( )	_____
Genitourinary	Frequent Urination	( )	( )	_____
	Impotent	( )	( )	_____

Musculoskeletal	Aching/sore muscles	( )	( )	_____
	Weakness	( )	( )	_____
Skin	Rash	( )	( )	_____
Neurologic	Tremor	( )	( )	_____
Psychiatric	Anxious	( )	( )	_____
Endocrine	Frequent urination at night	( )	( )	_____
	Intolerance to heat or cold	( )	( )	_____
Hematologic	Bleed or bruise easily	( )	( )	_____
Allergy/Immunology	Frequent infections	( )	( )	_____

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Dear Patient,

In order to give you the highest quality of care, please take a few minutes to complete tis section about your **PAST, FAMILY** and **SOCIAL MEDICAL HISTORY.** This will become part of your permanent medical records. Thank you!

Past Medical History: Please check each section if you have had the following problems:

( )	Angina	( )	High Cholesterol	( )	Varicose Veins
( )	Angioplasty	( )	Hypertension	( )	Other
( )	Asthma	( )	Murmur		_____
					_____
( )	Bypass	( )	Obesity	( )	Surgeries
( )	Diabetes	( )	Pacemaker		_____
( )	Dialysis	( )	Syncope (Pass Out)		_____
( )	Emphysema	( )	Rheumatic Fever		_____
( )	Heart Attack (MI)	( )	Stroke		
( )	Hiatal Hernia	( )	Ulcer/Gastritis		

The following section is about your **FAMILY'S MEDICAL HISTORY:**

Mother Living Age_____ Deceased Age_____

( )	Angina	( )	High Cholesterol	( )	Varicose Veins
( )	Angioplasty	( )	Hypertension	( )	Other
( )	Asthma	( )	Murmur		_____
					_____
( )	Bypass	( )	Obesity	( )	Surgeries
( )	Diabetes	( )	Pacemaker		_____
( )	Dialysis	( )	Syncope (Pass Out)		_____
( )	Emphysema	( )	Rheumatic Fever		_____
( )	Heart Attack (MI)	( )	Stroke		
( )	Hiatal Hernia	( )	Ulcer/Gastritis		

Family History
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Father Living Age_____ Deceased Age_____

( )	Angina	( )	High Cholesterol	( )	Varicose Veins
( )	Angioplasty	( )	Hypertension	( )	Other
( )	Asthma	( )	Murmur		_____
					_____
( )	Bypass	( )	Obesity	( )	Surgeries
( )	Diabetes	( )	Pacemaker		_____
( )	Dialysis	( )	Syncope (Pass Out)		_____
( )	Emphysema	( )	Rheumatic Fever		_____
( )	Heart Attack (MI)	( )	Stroke		
( )	Hiatal Hernia	( )	Ulcer/Gastritis		

Brother(s) Number Living _____Number Deceased_____
Sister(s) Number Living_____Number Deceased_____

( )	Angina	( )	High Cholesterol	( )	Varicose Veins
( )	Angioplasty	( )	Hypertension	( )	Other
( )	Asthma	( )	Murmur		_____
					_____
( )	Bypass	( )	Obesity	( )	Surgeries
( )	Diabetes	( )	Pacemaker		_____
( )	Dialysis	( )	Syncope (Pass Out)		_____
( )	Emphysema	( )	Rheumatic Fever		_____
( )	Heart Attack (MI)	( )	Stroke		
( )	Hiatal Hernia	( )	Ulcer/Gastritis		

The following section is about your **SOCIAL HISTORY:** (Check all boxes that pertain)

Marital Status: ( )Married ( )Divorced ( )Single ( )Separated ( )Widowed

Occupation(s) Exposure to: ( )Dust ( )Asbestos ( )Fumes ( )Chemicals ( )Other_____

Exercise Type(s)_____ Minutes_____ Days Per Week_____

Do you smoke: ( )Yes ( )No ( )Never Packs Per Day_____ Years Quit_____

Do you drink caffeinated beverages? ( )Yes ( )No How much do you consume?_____

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ACKNOWLEDGEMENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule is also created in order to provide a standard for certain health care providers to obtain their patients' consent for the use and disclosure of health information about the patient to carry out treatment, payment, or health care operations.

As our patients, we want you to know that we will respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We make every effort to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the **minimum necessary information** to only those we feel are in need of your health care information, and information about treatment, payment or health care operations, in order to provide care that is in your best interest.

I,_____, have full opportunity to read and consider the contents of Dr. Arno's Notice of Privacy Practices. I understand that, by signing his form, I am acknowledging the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature:_____**Date:**_____
(Patient signs here)

If a personal representative on behalf of the patient is signing this acknowledgement, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

Note: Anyone wishing a copy of Section I "Uses and Disclosures of HIPPA," please ask the receptionist.

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I understand that if I fail to cancel my scheduled appointment within 24 hours, I will be charged $50.00. I understand that Medicare and other insurance companies will not reimburse me for missed appointments. I understand that these charges are my full responsibility. By signing this I am agreeing to these terms.

Please initial_____

I understand that if my check is returned from the bank, for any reason, my account will be charged $35.00 in addition to the money owed.

Please initial_____

I understand that it is my responsibility to pay any co-pays, co-insurance and deductibles at time of service. If my account should become past due by **90 days,** I understand that the practice will charge at **5%** interest on these charges. I understand that Medicare and other insurance companies will not reimburse me for this interest. By signing this I am agreeing to these terms.

Please initial_____

I understand that if my insurance company requires that I need a referral for an office visit or procedure, I will provide Dr. Arno with a valid referral and make sure I have a valid referral at time of visit. I understand it is my responsibility to make sure I have a valid referral at time of service and, if I do not, I understand my insurance company will not pay Dr. Arno and I will be fully responsible for the visit. By signing this I am agreeing to these terms.

Please initial_____

I understand that Dr. Arno will make every effort to explain the cost of a procedure or medication. It is my responsibility to be aware of my insurance company's reimbursement guidelines and acknowledge I am fully responsible for anything they will not cover. By signing this I am agreeing to these terms.

Please initial_____

I understand that you will contact me through the phone numbers I have given you and consent to have Dr. Arno's staff leave messages on any of the phone numbers provided as it regards treatment and/or payment.

Patient Name_____Patient Signature_____
(Please Print)

Date_____

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PERMISSIONS

A) I hereby give permission for Dr. Arno's office to release information about my health or have the doctor speak with

_____ _____

Print Name Relationship to patient

_____ _____

Print Name Relationship to patient

B) In addition, messages pertaining to my treatment and appointments may be left on:

(Please check all that apply)

Home Phone _____

Cell Phone _____

Work Phone _____

_____ _____

Patient's Name (Please Print) Date of Birth

_____ _____

Patient's Signature Date