ILEANA ANTONIADIS M.D.
207 ROUTE 71
SPRING LAKE HEIGHTS, NJ 07762
TELEPHONE: 732-359-7232
FAX: 732-359-7233

PATIENT INFORMATION – ***PLEASE PRINT***

DATE OF APPOINTMENT: ________________

NAME: ____ HOME PHONE #:______________________________________
ADDRESS: ____ CELL PHONE #: _______________________________________
CITY: _________________ STATE: _______ ZIP CODE: ___________ EMAIL: _____________________________________
SOCIAL SECURITY #: ________________________ DATE OF BIRTH: ______________ AGE: _____ SEX: Male or Female
SEXUAL ORIENTATION (circle one): Heterosexual or Homosexual or Bisexual GENDER IDENTITY: Male or Female
EMPLOYER: ________________________JOB TITLE: _________________________ RETIRED (circle one): YES OR NO
MARITAL STATUS (circle one): S M W D SPOUSE'S NAME (if applicable): __________________________________
SPOUSE'S DOB: ________________ SPOUSE'S SOCIAL SECURITY #: ____

EMERGENCY CONTACT: ______________________ RELATIONSHIP: ________________ PHONE#: ___________________

PRIMARY CARE PHYSICIAN: __________________________ CITY/STATE: _________ PHONE #: ____________________

Please List **ALL** other Physicians/Specialist providing you Treatment:

Name	**Specialty**	**Phone Number (if known)**
______________________________	_______________________________	________________________________
______________________________	_______________________________	________________________________
______________________________	_______________________________	________________________________
______________________________	_______________________________	________________________________
______________________________	_______________________________	________________________________

WERE YOU REFERRED BY ANOTHER HEALTH CARE PROFESSIONAL? YES OR NO
IF YES, NAME AND PHONE # (if known): ____

ALLERGIES/Including: Medications, Seasonal, Latex, Etc… (CIRCLE ONE): YES OR NO
IF YES, NAME OF ALLERGEN: _________________________________REACTION: ________________________________
_________________________________REACTION: ________________________________
_________________________________REACTION: ________________________________
_________________________________REACTION: ________________________________

LOCAL PHARMACY: ___________________________ CITY/STATE: ___________ PHONE #: ________________________
MAIL-AWAY PHARMACY (if applicable): ____

PRIMARY INSURANCE COMPANY: ____
ID #: ____ GROUP #: ______________________________________
SECONDARY INSURANCE COMPANY: ____
ID#: ____ GROUP #: _______________________________________
PRESCRIPTION COVERAGE: NAME OF COMPANY (copy of card needed): _______________________________________

ILEANA ANTONIADIS M.D.

Insurance Agreement

PATIENTS WITH MEDICARE ONLY

I authorize treatment and give permission to Dr. Antoniadis and any of her authorized representatives to use my signature to electronically submit charges to Medicare for reimbursement.

I agree to pay all charges associated with the said treatment if not covered by Medicare and my secondary insurance (IE; Deductible, Co-Pay, Etc…)

A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL.

______________________________	____________________	________________
Signature	Relationship to Patient	Date

PATIENTS WITH COMMERCIAL INSURANCE ONLY

Dr. Antoniadis is not participating with any commercial insurance, Medicaid or Medicare Advantage plans at this time.

I Authorize treatment and agree to pay all charges associated with said treatment for services rendered at the time of examination.

A receipt will be given to me to submit to my insurance company for reimbursement.

I understand that I may protest any charges on these statements in writing within 30 days of the billing date.

I understand that I am finically responsible for any balance on my account and in the event that my account is placed with a collection agency, I will pay collection fees (33.5% of balance) and all court costs incurred by Dr. Antoniadis in addition to my balance.

A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL.

______________________________	____________________	________________
Signature	Relationship to Patient	Date

ILEANA ANTONIADIS M.D.

Initial Evaluation Form

Date Of Appointment: _______________

Patient Name: ___________________________________ **Date of Birth:** ___________________ **Age:** _________

Present Occupation: ____________________________ **Past Occupation** (if applicable)**:**______________________

Do you have children? (circle one) YES or NO **IF YES,** please provide # of children: __________

NATIVE INFORMATION (please circle):

RACE: White, African American, Asian, Other: ____________________

LANGUAGE(S) SPOKEN: English, Spanish, Other: ____________________

ETHNICITY: Hispanic, Latino, Greek, Irish, Italian, Other: ____

RELIGION: Christianity, Judaism, Hinduism, Islam, Buddhism, Other: ______________________________

FAMILY MEDICAL HISTORY: (if applicable) (if known)

FATHER: Known Illnesses: ____ Age at Death:________ Cause of Death: __________

MOTHER: Known Illnesses: ____ Age at Death:________ Cause of Death: __________

BROTHER: Known Illnesses: ____ Age at Death:________ Cause of Death: __________

SISTER: Known Illnesses: ____ Age at Death:________ Cause of Death: __________

CHILDREN: Known Illnesses: ____ Age at Death:________ Cause of Death: __________

SOCIAL HISTORY (please circle one):

Do you currently smoke? YES or NO **IF YES;** the # of year's: _____ /number of pack(s) per day: ______

Did you ever smoke? YES or NO **IF YES;** how long ago did you quit? ____________

Do you drink alcohol? YES or NO **IF YES;** number of drinks per day: __________

Do your drink (circle) COFFEE or TEA? **IF YES;** number of cups per day: ___________

PLEASE LIST ALL MEDICATIONS, ALL VITAMINS, AND ALL SUPPLEMENTS YOU ARE CURRENTLY TAKING:

Name	*Dose*	*Frequency*
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

PAST AND CURRENT MEDICAL ILLNESSES (please circle ALL that apply):

High Blood Pressure	Osteoporosis/ Osteopenia	Diabetes
Stroke/ TIA	Thyroid Disease	TB
High Cholesterol	Coronary Artery Disease/ A-Fib	Arthritis/ GOUT
Spine Arthritis/ Stenosis	Cancer(s) specify type/year diagnosed: ______________________________	

OTHER (please list):____

ALL PAST SURGERIES: Please list PROCEDURE and DATE:

____

____

____

ILEANA ANTONIADIS M.D.

New Patient/Initial Evaluation – Review Of System

Patient Name: ____ **Date of appointment:** ___________________

REASON FOR TODAY'S VISIT

Chief Complaint: **(Describe: Location, Severity, Associated Symptoms, Duration, Etc…)**

____
____
____
____

Please Circle Your Answer For Each Section:

Constitutional Symptoms		
Recent Weight Changes	Loss	Gain
Fever or Chills	No	Yes
Fatigue	No	Yes

Ears/Nose/Mouth/Throat		
Hearing loss	No	Yes
Mouth Sores or Oral Dryness	No	Yes
Swollen Glands	No	Yes
Dry Eyes	No	Yes

Cardiovascular		
Palpitations	No	Yes
Swelling of Feet, Ankles or Hands	No	Yes

Respiratory		
Chronic or Frequent Cough	No	Yes
Shortness of Breath	No	Yes

Gastrointestinal		
Loss of Appetite	No	Yes
Nausea or Vomiting	No	Yes
Frequent Diarrhea	No	Yes
Abdominal Pain or Heartburn	No	Yes

Genitourinary		
Frequent Urination	No	Yes
Burning or Painful Urination	No	Yes
Blood In Urine	No	Yes
Kidney Disease	No	Yes

Musculoskeletal		
Joint Pain	No	Yes
Joint Stiffness or Swelling	No	Yes
Weakness	No	Yes
Muscle Pain or Cramps	No	Yes
Cold Extremities/Raynaud's	No	Yes
Difficulty Walking	No	Yes

Skin		
Rash or Itching	No	Yes
Changes In Skin Color or Texture	No	Yes
Varicose Veins	No	Yes

Neurological		
Frequent or Recurring Headaches	No	Yes
Numbness or Tingling Sensations	No	Yes
Stroke	No	Yes

Psychiatric		
Memory loss or Confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Endocrine		
Excessive Thirst or Urination	No	Yes

Hematologic/Lymphatic		
Bleeding or Bruising Tendency	No	Yes
Anemia	No	Yes

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Patient Acknowledgement and Consent for Use and Disclosures of Protected Health Information (HIPAA)

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have rights to privacy regarding my protected health information: this information will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as appointment reminders, quality assessments, etc.

I acknowledge I have read and understand the displayed Notice of Privacy Practices (HIPAA) containing a more complete description of the uses and disclosures of my health information.

I understand that I may request in writing to amend restrictions on who has access to my personal health information (i.e. spouse) and if any limitations are requested I will notify the office immediately.

Are there any restrictions on who has access to your medical records? YES or NO
Please explain:
____
____

Patient Name: ______________________________________ **Date:** ________________

Relationship to Patient: ________________________________

Signature: ____

A copy of the notice of Privacy Practices (HIPAA) will be provided to me, if requested.

http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/Downloads/HIPAALaw.pdf

ILEANA ANTONIADIS M.D.

Patient Consents

Patient Consent for Medication History Reconciliation

I ______________________________ , **agree** to allow Dr. Antoniadis and her staff to obtain my medication history through our Electronic Health Record system.
Dr. Antoniadis will be allowed to view and import my current and/or previous medications that were prescribed to me by other physicians.

YES - OR - NO

(Please Circle One)

Signature: ______________________________________ Date: __________________

Patient Consent for Medically Necessary Procedures

I ______________________________ , **agree** to allow Dr. Antoniadis and/or her staff to perform medically necessary procedures as treatment or diagnosis, if needed. These procedures may include joint/tendon sheath injections and aspirations along with IV set up and venipuncture.

If you do not agree with this statement please check the box: ☐

Signature: ______________________________________ Date: __________________