STERLING SURGICARE, INC.

DR. AYOTUNDE ADEYERI

668 N. Beers St., Suite 103, Holmdel, NJ 07733
3 Hospital Plaza, Suite 206 Med Arts Bldg., Old Bridge, NJ 08857
901 W. Main St., Suite 103 Donna O'Donnell Med Arts Bldg., Freehold, NJ 07728
Phone #: 732.217.3897 Fax #: 732.739.9094

Today's Date: _____

Patient Name: _____
Last First M.I.

DOB: ____/____/____ SS#: _____ SEX: M F

AGE: _____

MARITAL STATUS: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____ Domestic Partner ____

ADDRESS: _____

HOME #: _____ CELL #: _____ WORK #: _____

If we need to call you, which phone # should we call first? _____ EMAIL: _____

EMPLOYER: _____ POSITION: _____

WORK ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE #: _____

Relationship to Patient: _____

PRIMARY INSURANCE: _____

ID#: _____ GRP #: _____ COPAY AMOUNT: $ _____

NAME OF INSURED: _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ REFERRAL REQUIRED: Yes No If YES, REF #: _____

SECONDARY INSURANCE: _____

ID#: _____ GRP #: _____ COPAY AMOUNT: $ _____

NAME OF INSURED: _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ REFERRAL REQUIRED: Yes No If YES, REF #: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

ADDRESS: _____

REFERRAL SOURCE:

▫ Primary Care Physician	▫ Friend	▫ Advertising
▫ Seminar	▫ Family	▫ Other _____
▫ Insurance Company	▫ Internet	

ASSIGNMENT OF INSURANCE BENEFITS:

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____hereby authorize _____
(NAME OF INSURED) **(NAME OF INSURANCE COMPANY)**
to pay and hereby assign directly to _____ all benefits, if any, otherwise payable to
(PROVIDER'S NAME)
me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any will be credited to my account, in accordance to the above said assignment.

_____ _____
(AUTHORIZED SIGNATURE OF SUBSCRIBER) **(DATE)**

STERLING SURGICARE, INC.

GENERAL MEDICAL HISTORY FORM

Name _____ SS#: _____

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit: _____

Present medications: **PLEASE ATTACH A LIST WITH NAME, DOSAGE AND FREQUENCY IF NEEDED**

_____

Allergies to medications: _____

Allergies (e.g. itchiness or hives) to specific brands of soap/laundry detergent: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include # of miscarriages and live birth): _____

_____

Previous problems with anesthesia? Yes ○ No ○

Do you smoke? Yes ○ No ○ If yes, how many packs a day? ____ Number of years smoked? _____

Used to, stopped ○ Year Quit _____

Do you regularly drink alcohol? Yes ○ No ○

Do you use drugs? Yes ○ No ○

PERSONAL MEDICAL HISTORY

Have you ever had any of the following (check all that apply)

○ Anemia	○ Arthritis	○ Asthma	○ Bladder Cancer
○ Bleeding Disorder	○ Blood Clots	○ Cancer (list) _____	
○ Crohn's Disease	○ Coronary Artery Disease	○ COPD	○ Congestive Heart Failure
○ Cirrhosis	○ Depression	○ Diabetes	○ Diverticulitis
○ Digestive Problems	○ Difficulty Hearing	○ Dizzy Spells	○ Emphysema
○ Fatty Liver	○ Fibromyalgia	○ Gastritis	○ GERD
○ Glaucoma	○ Gout	○ Heartburn	○ Heart Murmur
○ Heart Attack	○ Hepatitis	○ High Cholesterol	○ Hernia (type) _____
○ HIV/Aids	○ Hypertension	○ Hypothyroidism	○ Hemmorrhoids
○ Headaches	○ Irregular Rhythm	○ Incontinence	○ Kidney Disease
○ Kidney Stones	○ Lupus	○ Lung Disorder	○ Memory Loss
○ Multiple Sclerosis	○ Parkinson's Disease	○ Pseudotumor Cerebri	○ Polycystic Ovarian Syndrome
○ Reynaud's	○ Rheumatoid Arthritis	○ Seizures	○ Skin Disorders
○ Sleep Apnea	○ Stroke/TIA	○ Shortness of Breath	○ Tuberculosis
○ Ulcers	○ Ulcerative Colitis	○ Urine Infections	○ Vascular Disease

□ I HAVE NO MEDICAL PROBLEMS

FAMILY HISTORY

	FATHER SIDE			MOTHER SIDE		
	FATHER	MOTHER	PARENTS	FATHER	MOTHER	PARENTS
High Blood Pressure	○	○	○	○	○	○
Epilepsy	○	○	○	○	○	○
Cancer	○	○	○	○	○	○
Eczema/Psoriasis	○	○	○	○	○	○
Heart Attack/Stroke	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
Asthma	○	○	○	○	○	○
Hay Fever	○	○	○	○	○	○

DIET/WEIGHT LOSS HISTORY

When did you first start to have a weight problem? _____

When did you start to worry about your weight? _____

In your opinion, what contributes to your excess weight? _____

_____

What diets have you tried?

NAME OF PROGRAM/MEDICATION	DATE STARTED	HOW LONG	WEIGHT LOSS	HOW MUCH WEIGHT REGAINED
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PAST SURGICAL HISTORY

List all your operations (include dates) EXAMPLE: Hernia Repair 1991, etc.

▫ I have no surgical history

_____

_____

_____

_____

_____

Previous problems with anesthesia? ▫ YES ▫ NO

If yes, please explain

_____

_____

REVIEW OF SYSTEMS

Do you now or have you recently have any of the following problems? (Please circle YES or NO)

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Weight Change	Y	N
Night Sweats	Y	N

Other: _____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Heartburn	Y	N
Constipation	Y	N
Blood in Stool	Y	N
Diarrhea	Y	N

Other: _____

ENT

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problem	Y	N
Hay Fever	Y	N

Other: _____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Other: _____

Cardiovascular

Chest Pain	Y	N
Swelling of Feet	Y	N
Circulatory Problems	Y	N
Irregular Heartbeat	Y	N
Palpitations	Y	N

Other: _____

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Choking at Night	Y	N
Daytime Drowsiness	Y	N
Shortness of Breath	Y	N
Snoring	Y	N
Frequent Waking	Y	N

Other: _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness	Y	N
Tingling	Y	N
Hearing Loss	Y	N
Vision Loss	Y	N
Migraines	Y	N

Other: _____

Skin

Rash	Y	N
Boils	Y	N
Itching	Y	N
Skin Ulcers	Y	N
Cellulitis	Y	N
Skin Fold	Y	N

Other: _____

Hematology

Swollen Glands	Y	N
Bleeding Problems	Y	N
Anemia	Y	N

Other: _____

Psychologic

Depression	Y	N
Anxiety	Y	N
ADD/OCD	Y	N
Sexual Abuse	Y	N
Obsession	Y	N
Hyperactivity	Y	N
Alcoholism	Y	N

Musculoskeletal

Joint Pain	Y	N
Back Pain	Y	N
Weakness	Y	N
Difficulty Walking	Y	N
Limited Mobility	Y	N

Other: _____

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other: _____

SOCIAL HISTORY

Do you smoke?
▫ NO
▫ YES If yes, how many packs a day? _____
Year started smoking _____

▫ USED TO Year quit _____
▫ NEVER

Do you drink alcohol?
▫ NO
▫ YES How often? ▫ Daily ▫ Weekly ▫ Occasionally ▫ Rarely
If yes, how many glasses per week? _____

Do you use recreational drugs?
▫ NO
▫ YES If yes, which ones? _____
▫ USED TO

ADVANCE BENEFICIARY NOTICE

In the event that I lose my health insurance benefits and become a self-paying patient. I acknowledge and understand that I am responsible for all of the medical services rendered to me by the physician/s of STERLING SURGICARE, INC. as well as for any unpaid cash balances to my account.

_____ _____
PATIENT'S NAME DATE

_____
SIGNATURE OF PATIENT/GUARANTOR

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PHONE #: 732.217.3897 FAX #: 732.739.9094

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and 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 the third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received you **NOTICE OF PRIVACY PRACTICES** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has rights to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address above to obtain my current copy of Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you agree then you are bound to abide by such restrictions.

PATIENT NAME: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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RELEASE OF MEDICAL INFORMATION CONSENT FORM

Due to new HIPPA (Health Insurance Portability and Accountability Act), we are limited as to what information in your medical records can be shared with any other person except you. BY INTIALING THE APPROPRIATE LINES BELOW, YOU ARE ALLOWING OUR OFFICE TO RELEASE YOUR HEALTHCARE INFORMATION IN LIMITED CASES. You may revoke your consent at any time, in writing, to our office.

I, _____, give my consents to STERLING SURGICARE, INC. to:

_____ Speak with my family members/spouse about my Medical Condition, Labs, Radiology Results, AND/OR Treatment Plans. (Please list person/s who are to release information to and their relation to you on the provided line below)

_____

_____

_____

_____

_____

_____

_____ Fax my test results to other physicians who are participating in my care.

_____ Telephone my phone to confirm appointments

_____ Telephone my work to confirm appointments

_____ Leave messages on my answering machine with regards to test results

_____ Other (please specify)

Patient's Name (PRINT): _____

Patient's Signature: _____

Date: _____

OFFICE USE ONLY
Staff Signature: _____
Date: _____

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COMPLIANCE AGREEMENT FOR BARIATRIC PATIENTS

The decision to have bariatric surgery is a very serious one and I understand the commitment and sacrifices I must make to have a successful outcome.

I also understand and agree that I will not gain any additional weight from the date of my initial consultation to my scheduled surgical date. If I fail to keep this agreement, I understand that my surgery may be postponed or even canceled.

Date: _____

Patient's Name: _____

Patient's Signature: _____

Witness Signature: _____

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PHOTO AUTHORIZATION AND RELEASE

I hereby authorize STERLING SURGICARE, INC. to display my photographs and statements on the website and other avenues.

Patient's Name: _____

Patient's Signature: _____

Date: _____

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MEDICAL RECORDS REQUEST

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

_____

I hereby authorize STERLING SURGICARE, INC. to obtain any and/or all of my medical records pertaining to my care and treatments from _____ to _____.

( ) Please fax to 732.739.9094

( ) Please mail medical records to 668 N. Beers St., Suite 103, Holmdel, NJ 07733

I release you from all legal responsibility that may arise from this authorization.

Signature: _____ Date: _____

Witness: _____ Date: _____