

# Millville Medical Center

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**M.A. Piszcz-Connelly, M.D., F.A.C.P.**  
1700 North 10<sup>th</sup> Street  
Millville, New Jersey 08332  
Phone: 856-327-6446  
Fax: 856-327-0158

Dear Patient,

Enclosed you will find a packet of forms that will need to be filled out for your initial visit with our office.

Please review the forms (front & back), fill in the information, and sign each form. Please bring these forms with you to your first visit. You will also need to bring your insurance card and your co-payment.

If you have a co-payment with your insurance it is **due at the time of visit**. We accept cash, check, and Visa/Mastercard check cards for payment.

If you take any prescription medication we ask that you **please bring all the medication/bottles with you** to your first appointment. This ensures that we get accurate information.

If you have any questions in regards to the forms or need further information prior to your first visit, please contact our office at the above number. Please feel free to call with any questions in regard to our office or your visit.

Thank you for your time and attention and welcome to our office.

Sincerely,  
Millville Medical Center Staff

\*\*\* If your insurance requires you to pick a primary care doctor please call and have the information updated before your visit. They will ask for our provide ID number or our tax id number. We have provided a list below to help you.

**Dr. Piszcz-Connelly ID #'s**  
Tax ID # 37-1460625  
Horizon ID # K3960  
Aetna #3133  
Amerihealth # 2143164001

Please only fill out this form if you would like us to obtain records from your last physician

## Millville Medical Center

MALGORZATA A. PISZCZ-CONNELLY M.D., F.A.C.P.  
1700 N 10th STREET  
MILLVILLE, NJ 08332

### MEDICAL RECORD RELEASE AUTHORIZATION TO OBTAIN RECORDS FROM ANOTHER OFFICE

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PATIENT SS#: \_\_\_\_\_

Name and  
address of  
your previous  
doctor or facility  
we will be obtaining  
records from \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am requesting copy of my records be forwarded to the physician listed below.

### RELEASE COPY OF MY RECORDS TO:

Millville Medical Center  
M.A. Piszcz-Connelly, M.D., F.A.C.P.  
1700 North 10<sup>th</sup> Street  
Millville, NJ 08332  
856-327-6446  
856-327-0158 (Fax)

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# Medical History

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Sex  Male  Female  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
Phone \_\_\_\_\_  
 Single  Married  Divorced  Widowed  Separated  
If married, spouse's name \_\_\_\_\_  
Children's names and ages \_\_\_\_\_

**Allergies to Medications, X-Ray Dyes, or Other Substances**  No  Yes  
(If yes, please list name of medicine and type of reaction)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History and Review of Systems**  
Please check off if you have had any problems with or are presently experiencing any of the following:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Unexplained weight gain/loss	<input type="checkbox"/> Low back problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Skin diseases
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> T.B.	<input type="checkbox"/> Gall Bladder disease	<input type="checkbox"/> Blood disorders
<input type="checkbox"/> Chest pain/chest tightness	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Colitis	<input type="checkbox"/> Venereal diseases
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Abdominal discomfort	<input type="checkbox"/> Hepatitis or jaundice	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Nausea	<input type="checkbox"/> Head or neck radiation	<input type="checkbox"/> Anemia
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Headache	<input type="checkbox"/> Alcohol abuse
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Gout
<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Impotence or Erectile Dysfunction
	<input type="checkbox"/> Ulcers		<input type="checkbox"/> Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Gynecologic and Obstetric History**  
Age at onset of periods \_\_\_\_\_ Frequency \_\_\_\_\_ Length of period \_\_\_\_\_  
Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_  
Prolonged or abnormal bleeding  No  Yes (Please describe) \_\_\_\_\_  
Leakage of urine  No  Yes (Please describe) \_\_\_\_\_  
Pelvic pain  No  Yes (Please describe) \_\_\_\_\_  
Abnormal discharge  No  Yes (Please describe) \_\_\_\_\_  
History of abnormal Pap smear  No  Yes (Please describe) \_\_\_\_\_

This information is for use by your physician as part of your confidential medical record.

*Please continue on the next page*

# Medical History

Name \_\_\_\_\_

Date \_\_\_\_\_

## Please List and Supply the Dates of:

Operations \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Hospitalizations other than for surgery \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Immunization history—have you had:

Hepatitis B?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When? _____	Pneumovax immunization?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When? _____
Other?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When? _____	Flu immunization?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When? _____
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When? _____	Tetanus immunization?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When? _____

When was your last:

Pap Smear?	_____	Breast Exam?	_____	Stool check for blood?	_____
Mammogram?	_____	Cholesterol check?	_____	Prostate exam?	_____

## Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed?
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc.)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Other _____	_____	_____

## Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

## Prevention

Do you wear seat belts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, why not? _____
Do you wear a bike helmet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you exercise regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, type, duration and number of times per week? _____
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much per week? _____
Do you drink coffee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many cups per day? _____
Do you drink tea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many cups per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Do you wish to be tested for AIDS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you ever feel afraid of your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Do you have a "living will"?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a donor card?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Method of birth control? _____			

**Please only fill out this form if you would like to give a spouse or family member authorization to obtain your medical information or medical results.**

## **Millville Medical Center**

**M.A. Piszcz-Connelly, M.D., F.A.C.P.**

**1700 North 10<sup>th</sup> Street**

**Millville, New Jersey 08332**

**Phone: 856-327-6446**

**Fax: 856-327-0158**

**Patient Name:** \_\_\_\_\_

I give permission to release any medical information pertaining to myself to the names listed below. If you are unable to contact me or if said person calls the office to obtain results or information I authorize your staff to release the information to them. I do understand that this form will be kept on record.

**Please list ONLY the name of persons authorized to obtain information and their relationship to you.**

I authorize the following people to call or obtain any of my medical information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OR**

I do not give permission to release information to anyone other than myself.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

## Billing Information

**Insurance** - We can not bill your insurance company unless you give us the proper insurance information. Please provide us with your insurance card so that a copy can be made. A claim will be billed to your insurance company if we have all the proper information. We will make every effort over the next 60 days to get your insurance claim paid. However, if your insurance company does not make payment on the claim within 60 days the bill will automatically be billed directly to you. Your insurance is a contract between you and your insurance company. If you receive a bill that your insurance company did not pay, please contact them as soon as possible. In most cases once the insurance company receives a call from the patient the payment is made on your claim.

**All co-pays are due at the time of visit. We accept cash, check and debit cards for payment.**

**Self Pay** - Self-pay patients with no insurance coverage will be responsible in full for their bill. Payment will be due at the time of visit.

## Assignment of Benefits

I hereby authorize Millville Medical Center to bill my insurance, which may include release of medical information to process the claim for payment. I hereby authorize payment to be made directly to Millville Medical Center. I have read and understand the financial policy and agree to abide by this policy.

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Patient Signature

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Date

## Notice of Privacy Practices Millville Medical Center

Millville Medical Center and all staff understand that your medial information is personal and we follow all legal requirements in regard to the HIPPA laws. A detailed description of our Notice of Privacy Practices is in our waiting room and is available for all patients by request. We WILL NOT disclose patient results to anyone other than the patient. This means that we will not disclose information to any family member including husband, wife, child and/or parent. Information will only be disclosed to another person if the patient signs an authorization form stating whom information can be released to. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information in regards to your care.

**You have the right** to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice be we do reserve the right to change the terms of our Notice.

**You have the right** to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. Please let us know of your concerns or complaints in writing.

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Patient Signature

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Date