Alvin Bell, M.D, F.A.C.P., F. A. S.N.
Nephrology and Hypertension
129 Grove Street
Montclair, New Jersey 07042
Telephone: 973-783-6110
Facsimile: 973-744-7385

WELCOME TO THE OFFICE OF DR. ALVIN BELL
OUR NEW PATIENT PACKET INCLUDES :

HIPPA FORM
DEMOGRAPHIC FORM
MEDICATION FORM
MEDICAL HISRTORY FORM
CONSENT TO ELECTRONICALLY SEND PRESCRITIONS

Please fill out both sides of the Medical History form. Each question MUST be Circled/checked YES or NO sign at all X's listed (patient signature)

- Please arrive 30 minutes before appointment to register with front desk
- You must bring a referral from your physician if needed (please check with your health insurance carrier)
- Please bring all medication bottles (if on insulin that's needs refrigeration bring in box)
- Please bring a copy of your most recent blood work and/or notify your doctor's office the date of your appointment with our office and have
- pertinent data faxed to 973-744-7385
- If you have had any additional tests, x-rays etc. please bring in copies of reports

Do not forget your insurance card, photo identification and referral

Co-Payments will be collected on the date of service
Payments are payable via check, cash or money order only

THERE IS A $25.00 CAHRGE FOR ANY APPOINTMENT NOT CANCELLED WITHIN 24 HOURS

If you have any questions or concerns please call the office @ 973-783-6110

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices for:

ALVIN BELL, M.D., F.A.C.P., F.A.S.N

Print Patient Name:_____

Signature of Patient:_____

Date:_____

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

Please list family members or other persons whom we may inform about your general medical condition, appointments and your diagnosis (including treatment, payment and health care operations)

NAME_____ Contact #_____

NAME_____Contact #_____

Is it ok to send your prescription's electronically to your pharmacy _____Y _____N?
Is it ok to leave a voicemail regarding appointments Y_____ N_____?
Is it ok to call your cell phone Y_____ N_____?
If so please list number _____
Is it ok to leave voicemails on your cellular phone Y_____ N_____?

I patient/ representative request a copy of the Notice of Privacy Practices: Yes_____ No_____

For Office Use:

If patient/representative requested copy of Notice, date copy was provided:_____
If no acknowledgement could be obtained, state the reasons why and the efforts taken to try to obtain the acknowlegment:_____
_____

ALVIN BELL, M.D., FACP, FASN

129 GROVE STREET MONTCLAIR, NEW JERSEY 07042

Name_____ Date_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone #_____ Work #_____ Cell Phone #_____

Date of Birth_____ Age_____ Sex_____

Social Security #_____ Driver License #_____

Preferred Language_____ Race_____ Ethnicity_____

Email Address_____

Next of Kin (Emergency Contact):

Name_____ Phone #_____

Street Address_____ City, State, Zip Code_____

Referred By:_____

Illness_____ Employment_____ Car Accident_____ Other_____

Primary Insurance_____

Insurance Company Address_____

Identification #_____ Group #_____ Holder_____

Secondary Insurance_____

Identification #_____ Group #_____ Holder_____

Hereby assign my insurance benefits for in-patient hospital services to be paid to my physician. I understand that I am financially responsible for the difference between the amount billed and the amount paid by my insurance carrier. I understand that I am responsible for all charges occurred in the office at time of service.

Signed:_____(Patient, or Parent, if minor)

Hereby authorize you to release to Insurance Companies all information including the diagnosis and records of any treatment or examination rendered to me in this office.

Signed:_____(Patient, or Parent, if minor)

"If my delinquent account is sent to a collection agency, I agree to the addition of a collection fee of $50 or 20% of the balance owed, which ever is greater."

Signed:_____(Patient, or Parent, if minor)

Name _____ Age _____ Single / Married / Divorced / Widow(er) _____ Date _____

Occupation _____ All Previous Occupations _____

Birth Place _____ Birthdate _____ List all States in which you have lived _____

Education: _____ years High School _____ years College _____ years Post Grad

Date of last physical examination _____

Please list all Symptoms

1. _____
2. _____
3. _____
4. _____
5. _____

Routine Check-up - No Symptoms ☐

NOTE: This is a confidential record of your medical history and will be kept in this office. Informatic contained here will not be released to any person except when you have authorized us to do so or by cou order.

To the best of my knowledge, the questions on this form have been accurately answered. I understand th providing incorrect information can be dangerous to my (my child's) health. It is my responsibility t inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthca staff to perform the necessary health care services I (my child) may need.

PATIENT SIGNATURE _____

PHYSICIAN'S REVIEW SIGNATURE _____

	If Living: Age	Health	If Deceased: Age at death	Cause	Has any blood relative ever had:	Please encircle No or Yes		Who
Father					Cancer	No	Yes	
Mother					Tuberculosis	No	Yes	
Brother or Sister 1.					Diabetes	No	Yes	
2.					Heart Trouble	No	Yes	
3.					High Blood Pressure	No	Yes	
4.					Stroke	No	Yes	
Husband or Wife					Epilepsy	No	Yes	
Son or Daughter 1.					Insanity	No	Yes	
2.					Suicide	No	Yes	
3.								
4.								

PERSONAL HISTORY

ILLNESSES: Have you ever had

PLEASE ENCIRCLE ALL ANSWERS		
Measles	No	Yes
German Measles	No	Yes
Mumps	No	Yes
Chicken Pox	No	Yes
Whooping Cough	No	Yes
Scarlet fever or Scarlatina	No	Yes
Diphtheria	No	Yes
Smallpox	No	Yes
Pneumonia	No	Yes
Influenza	No	Yes
Pleurisy	No	Yes
Rheumatic Fever or Heart Disease	No	Yes
Arthritis or Rheumatism	No	Yes
Any bone or joint disease	No	Yes
Neuritis or Neuralgia	No	Yes
Bursitis, Sciatica or Lumbago	No	Yes
Polio or Meningitis	No	Yes
Nephritis	No	Yes
Gonorrhea or Syphilis	No	Yes
Gallbladder disease	No	Yes
Anemia	No	Yes
Jaundice	No	Yes
Bladder disease	No	Yes
Epilepsy	No	Yes
Migraine headaches	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Cancer	No	Yes
High or low blood pressure	No	Yes
Colitis or other bowel disease	No	Yes
Hemorrhoids or any rectal disease	No	Yes
Nervous Breakdown	No	Yes
Food, chemical or drug poisoning	No	Yes
Hay fever or Asthma	No	Yes
Hives or Eczema	No	Yes
Frequent infections or boils	No	Yes
AIDS	No	Yes
Any other disease	No	Yes

ALLERGIES: Are you allergic to

Penicillin or Sulfa	No	Yes
Aspirin, Codeine or Morphine	No	Yes
Mycins or other Antibiotics	No	Yes
Merthiolate or Mercurochrome	No	Yes
Any other drug	No	Yes
Any foods	No	Yes
Adhesive Tape	No	Yes
Nail polish or other cosmetics	No	Yes
Tetanus Antitoxin or Serums	No	Yes

INJURIES: Have you had any

Broken or cracked bones	No	Yes
Sprains	No	Yes
Lacerations	No	Yes
Dislocations	No	Yes
Concussion, or head injury	No	Yes
Ever been knocked unconscious	No	Yes

WEIGHT: Now _____ One Year Ago _____

Maximum _____ When _____

TRANSFUSIONS: Have you ever had

Blood or Plasma Transfusion	No	Yes

SURGERY: Have you had

Tonsillectomy	No	Yes
Appendectomy	No	Yes
Any other operation	No	Yes

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

Do you smoke No Yes

How many per day _____

Have you ever been advised to have any surgical operation which has not been done _____ No Yes

Have you been hospitalized for any illness _____ No Yes

Give details:

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent or severe headaches ____ No Yes
Fainting spells ____ No Yes
Dizziness on change of position ____ No Yes
Unconscious Spells ____ No Yes
Blurred Vision ____ No Yes
Double Vision ____ No Yes
Spots before eyes ____ No Yes
Infected eyes ____ No Yes
Pain behind eyes ____ No Yes
Any change in vision ____ No Yes
Do you wear glasses ____ No Yes
When were they last checked ____
Earaches ____ No Yes
Discharge from Ears ____ No Yes
Ringing in ears ____ No Yes
Decrease in hearing ____ No Yes
Recurrent nose bleeds ____ No Yes
Recurrent head colds ____ No Yes
Sinus Trouble ____ No Yes
Hay fever ____ No Yes
Strange persistent odors ____ No Yes
Strange taste or loss in taste ____ No Yes
Persistent hoarseness ____ No Yes
Difficulty swallowing ____ No Yes
Enlarged glands ____ No Yes
Recurrent sore throats ____ No Yes
Recurrent sores in mouth ____ No Yes
Soreness or bleeding of gums on brushing ____ No Yes
Chest pain ____ No Yes
Angina pectoris ____ No Yes
Coughed up blood ____ No Yes
Pain in arm(s) ____ No Yes
Night sweats ____ No Yes
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ____ No Yes
Chronic or frequent cough on lying down ____ No Yes
Wake up at night short of breath ____ No Yes
How many bed pillows do you use ____
Shortness of breath on:
Walking several blocks ____ No Yes
One flight of stairs ____ No Yes
On lying down ____ No Yes
Purple lips or fingers ____ No Yes
Palpitations or fluttering of heart ____ No Yes
High blood pressure ____ No Yes
Swelling of hands, feet or ankles ____ No Yes
At what time of day ____
Leg cramps on walking or at night ____ No Yes
Enlarged veins in legs ____ No Yes
Recurrent stomach pain ____ No Yes
Belching or heartburn ____ No Yes
Relieved by food or medication ____ No Yes
Appetite - Good ☐ Fair ☐ Poor ☐
Nausea or vomiting ____ No Yes
Vomited blood ____ No Yes
Avoid some foods ____ No Yes
What kinds ____
Avoid spices ____ No Yes
Abdominal cramping ____ No Yes
Color of bowel movement ____
Any blood in BM ____ No Yes
Rectal pain with bowel movement ____ No Yes

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Change in size, shape or texture of BM ____ No Yes
Describe ____
Pain on urinating ____ No Yes
Difficulty in starting urination ____ No Yes
Do you get up at night to urinate ____ No Yes
How many times ____
Urinate more than before ____ No Yes
Urinate less than before ____ No Yes
Any blood in urine ____ No Yes
How many times per day do you urinate ____
Full feeling of bladder, but only small amount of urination ____ No Yes
Lose urine on coughing or sneezing ____ No Yes
Discharge from penis ____ No Yes
Recurrent back pains ____ No Yes
Backaches ____ No Yes
Joint pains ____ No Yes
Swelling of any joints ____ No Yes
Redness or heat of any joint ____ No Yes
Tingling or weakness of hands or feet ____ No Yes
Muscle Spasms ____ No Yes
Loss or change in sensation of hands or feet ____ No Yes
Trembling of any extremity ____ No Yes
Growth in neck or throat ____ No Yes
Hot flashes ____ No Yes
Tiredness without apparent reason ____ No Yes
Brittleness of nails ____ No Yes
Dryness of skin ____ No Yes
Easy bruising ____ No Yes
Inability to stand heat ____ No Yes
Inability to stand cold ____ No Yes
Change in hair texture ____ No Yes
Change in skin texture ____ No Yes
Any skin rash ____ No Yes

X-RAYS: Have you ever had x-rays of
Chest ____ No Yes
Stomach or colon ____ No Yes
Gall bladder ____ No Yes
Extremities ____ No Yes
Back ____ No Yes
Teeth ____ No Yes
Other ____ No Yes

EKG: Ever had an electrocardiogram? ____ No Yes

IMMUNIZATIONS: Have you had
Smallpox vaccination within last 7 years ____ No Yes
Tetanus shots (not antitoxin which lasts only 2 weeks) ____ No Yes
Polio shots within last 2 years ____ No Yes

DRUGS: Laxatives; never ☐ occ. ☐ freq. ☐ daily ☐
Vitamins; never ☐ occ. ☐ freq. ☐ daily ☐
Sedatives; never ☐ occ. ☐ freq. ☐ daily ☐
Tranquilizers; never ☐ occ. ☐ freq. ☐ daily ☐
Sleeping pills, etc.; never ☐ occ. ☐ freq. ☐ daily ☐
Aspirin, etc.; never ☐ occ. ☐ freq. ☐ daily ☐
Cortisone, ACTH; never ☐ occ. ☐ freq. ☐ daily ☐
Thyroid; never ☐ yes, in past, none now ☐
daily ☐ now on ____ gr. day
Appetite depressants never ☐ occ. ☐ freq. ☐ daily ☐

Have you ever been treated for drug habits ____ No Yes
Have you ever taken insulin or tablets for diabetes ____ No Yes
Have you ever taken hormone tablets or injections ____ No Yes
Have you ever taken Fen-Phen/Redux ____ No Yes
SEX: Entirely satisfactory? ____ No Yes

WOMEN ONLY - MENSTRUAL HISTORY

Age at onset ____
Regular? ☐ Yes ☐ No ☐ Varies
Cycle ____ days (from start to finish)
Flow: Heavy ☐ Medium ☐ Light ☐
Number of pads used per period ____
Any clots passed ____ No Yes
Pains or cramps ____ No Yes
Date of last period ____
Date of last pelvic exam ____
Date of last Pap Test ____
Results: ☐ Neg. ☐ Pos.
Any discharge from vagina ____ No Yes
If so, color ____
amount ____
Any itching of vaginal area ____ No Yes
Do you take birth control pills ____ No Yes
How long have you taken them ____
Pregnancies:
How many children born alive ____
How many still births ____
How many premature births ____
How many Cesarean Sections ____
How many miscarriages ____
Any complications with pregnancy ____ No Yes
Describe ____
Other ____

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E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors, and enhances convenience for the patient while maximizing patient safety. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the patient's drug benefit plan.
- Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize adverse drug events.
- Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription needs to be refilled, has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Alvin Bell, M.D., can electronically transmit your prescriptions directly to your pharmacy.

E-Prescribing is an optional service and you may choose to decline. Please note that consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers and/or third-party benefit payers (i.e., your insurance company) for treatment purposes only.

Understanding all of the above, I hereby provide informed consent to Alvin Bell, M.D. to enroll me in the E-Prescribe Program.

_____ _____

Signature of Patient Date of Birth

_____

If person signing is not patient please print name and relationship above

If you choose to participate in E-Prescribing, please list your preferred pharmacy information below.

_____

Pharmacy Name Location-(City and Street Name)

_____

Pharmacy Telephone Number

MEDICATION LIST - NEW PATIENT

DO YOU GIVE PERMISSION TO SEND PRESCRIPTIONS ELECTRONICALLY TO YOUR PHARMACY _____Y _____N?

BEFORE YOUR APPOINTMENT PLEASE COMPLETE THIS FORM. YOU MAY COPY THE NAMES, DOSES AND TIMES FROM EXSISTING MEDICATION LABELS.

PLEASE BRING ALL MEDICATIONS WITH YOU

NAME _____

PHARMACY _____ TELEPHONE# _____

DRUG ALLERGIES: _____

MEDICATION:	DOSE:	FREQENCY: