Nadia Ali, MD – Internal Medicine
Rohail Asrar, MD – Internal Medicine
Najaf Asrar, MD – Adult Endocrinology

986 Shoppes Blvd.
North Brunswick, NJ 08902
P. 732-497-5000
F. 732-497-5001

NBMA
NORTH BRUNSWICK MEDICAL ASSOCIATES

Patient Registration Form

Last Name: _____ First Name: _____

Middle Initial: _____ Date of Birth: ___/___/____ Sex at Birth: [ ] M [ ]F

SSN_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: [ ]Home [ ]Mobile [ ]Work (_____)_____-_____

Alternative Phone Number: (_____)____-_____

Email Address: _____

Employer

Name: _____ Role: _____

Phone Number: (_____)____-_____

Insurance

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Emergency Contact

Name: _____

Relationship: _____ Phone Number: (_____)____-_____

- I certify this information to be true and correct to the best of my knowledge. I will notify the office of any changes in my health or the above information.
- I understand and agree that regardless of any insurance status I am ultimately responsible for the balance of my account. I understand that there is a $20 charge if I fail to cancel my appointment at least 24 hours in advance and will be charged at the time of my next visit.
- I understand the physicians do not refill controlled substance pain killers prescribed by other providers.
- Our notice of Privacy Practices provides information about how we may use and disclose your protected health information. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
- By signing this form, you consent to our use and disclosure of protected health information about you for treating, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provided this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPPA).
- You agree to allow us to send you electronic appointment notifications through email and or text message.
- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice may condition receipt of treatment upon the execution of this consent.

Printed Name of patient or representative_____

Relationship if other than patient_____

Signature_____ Date _____

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I,_____, hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT scan, this timely recommendation is important and essential the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Name_____

Signature_____ Date_____

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

AUA Symptom Score Questionnaire

The American Urological Association (AUA) has created this symptom index to give you and your physician an understanding of the severity of your enlarged prostate symptoms.

Question	None	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your score
Incomplete emptying: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
Frequency: Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5	
Intermittency: Over the past month, how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency: Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
Weak-stream: Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining: Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
Nocturia: Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	

Symptom Score

(Add up the points for all questions to determine the severity of your symptoms)

Total score

If you scored 8 points or higher, you should consult your physician.

Symptom Score (Severity) — **0 to 7** (Mild), **8 to 19** (Moderate), **20 to 35** (Severe)