HENRY J. AUSTIN™
HEALTH CENTER
The center for wellness

HEALTH FAIR REGISTRATION FORM

Patient's name: _____

Date of Birth: _____

Parent/Guardian name: (Must provide proof)

_____

Address:

_____

_____

Telephone: Home #_____ Cell # _____

Email: _____

Insurance:

YES_____ (Must be a HJAHC patient and provide insurance cards)

NO_____ (Must provide proof of address and income)

VFA/VFC Status: _____

_____

Emergency Contact / Next of Kin:

Name: _____

Relationship: _____Telephone: _____

CERTIFICATION

I hereby certify the information given is correct. _____

Signature of Responsible Person Date

AUTHORIZATION

I hereby authorize Henry J. Austin Health Center, Inc. and its physicians, employees, agents and contractors to deliver and administer such health care services, drugs, medications, and immunizations and to perform such diagnostic procedures as may be necessary for the proper health of the patient. I hereby authorize Henry J. Austin Health Center physicians, employees, agents and or business associates, including the LabCorp phlebotomist, to contact the patient regarding appointments or reminders for my health care management.
I acknowledge receipt of Henry J. Austin Health Center, Inc. Patient Rights pamphlet.

_____ _____

Responsible Person Date

_____ _____

Responsible to Patient Date

CERTIFACIÓN

Yo certifico que esta información es correcta _____ _____

Firma Fecha

AUTORIZACION

Yo autorizo al Henry J. Austin Health Center, Inc., y a sus medicos, empleados, agentes y contratistas a suministar y a administrar servicios do salud tales como drogas, medicamentos vacunas y administar tratamiento que sea necessario para mi bienestar como paciente. Autorizo a los médicos del centro de salud de Henry J. Austin, empleados, agentes y o asociados de negocios, incluyendo el flebotomista LabCorp, para comunicarse con el paciente en cuanto a citas o recordatorios para mi administración de cuidado de la salud.
Yo certifico que recibé el panfleto del los Derechos del Paciente de Henry J. Austin Health Center, Inc.

_____ _____

Firma del padre o encargado legal / Si es menor firma del padre Fecha

_____ _____

Relación con el paciente Fecha

Henry J. Austin Health Center, Inc. provides comprehensive health services to residents of Trenton and the surrounding communities. Many of these services are supported by local, state and federal agencies. It is unlawful to apply for and to obtain services provided at HJAHC when the individual or members of the individual's family has insurance coverage that pays for all or a portion of such services.

According to N.J.C.A 2C:20-8(a) "A person is guilty of theft if he purposely obtains services which he knows are available only for compensation, by deception or threat, or through fraudulent statements, to avoid payment for the services."

I certify that the services on this claim have been rendered. I authorized Henry J Austin Health Center to release medical or other information date related to this claim to the Division of Medical Assistance, the Health Care Financing Administrator and/or other insurance agencies. I permit a copy of this authorization to be used and I request payment of benefits to the party, which accept assignment. I understand I am responsible for any Medicare Insurance deductible and co-payment as required.

El centro de salud Henry J. Austin Health Center, Inc. Ofrece servicios de salud comprensivos a los residentes de Trenton y las comunidades que le rodean. Muchos de estos servicios son pagos por agencinas locales, estatales y federales. Es ilegal aplicar y obtener servicios ofrecidos por el centro de salud HJAHC cuando el individuo o miembros de la familia del individuo son cubiertos por seguros que pagan todo o parte de dichos servicios.

De acuendo a N.J.S.A. 2C:20-8(a) "El individuo es culpable de fraude si intencionalmente obtiene servicios que son ofrecidos solo por compensation por decepción o amenasa…o por declaración fraudalenta, para evitar pago por los servicios."

Yo certifico que los servicios en esta reclamacion han sido recibidos. Yo authorizo que el Centro Henry J. Austin entregue informacion medica o otra informacion relacionada a este reclamo a la Division de Asistencia Medica, al Administrador financiero de Cuido de Salud y/o otros agencias authorizacion de seguro. Yo permito que una copia de esta autorizacion sea utilizada y solicitado pago de beneficios al grupo que acepte esta asignacion.. Yo entiendo que soy responsable de pagar el costo deducible del Seguro de Medicare o otros pagos que sean requeridos.

_____ _____

Signature of Patient/Responsible Person Date

HENRY J. AUSTIN™
HEALTH CENTER
The center for wellness

Henry J. Austin Health Center en Warren, 321 N. Warren Street
Trenton, NJ 08618
(609) 278-5900 Fax (609) 965-3532

Henry J. Austin Health Center en Ewing, 112 Ewing Street
Trenton, NJ 08609
(609) 278-5900 Fax (609) 392-6453

Henry J. Austin Health Center en Chambers, 317 Chambers Street
Trenton, NJ 08609
(609) 278-5900 Fax (609) 392-3679

Henry J. Austin Health Center en Bellevue, 433 Bellevue Ave. 4° piso
Trenton, NJ 08618
(609) 278-5900 Fax (609) 392-8639

CONSENT BY PROXY
Authorization to Escort and Treat Minor in Parent/Guardian's Absence

****Use a separate form for each child****

Date _____

I _____, cannot at times accompany my child to Henry J. Austin Health Center and therefore authorize the following individual(s) listed below to bring in my child, _____ for a sick visit, follow up visits (which may include immunizations) or dental treatment. I will be advised of any specific immunizations necessary for my child, and made aware of any known benefits and risks before immunizations are administered to my child. I authorize Henry J. Austin Health Center's medical personnel to attend to my child, and issue my consent for any necessary medical care during these visits as deemed advisable. I authorize the escort to receive Henry J. Austin Health Center's provider's treatment plan and medical recommendations for my child. For any other non-emergency treatment recommendations, I may be called at the number on this form for my verbal consent.

Security Question: What is the child's grandmother's (or legal guardian's mother's) first name (on mom's side of the family)?
Security Answer: _____

	NAME (Please Print)	Relationship to Child	Contact Number
1.			
2.			
3.			

Expiration Date: _____ My child's date of birth is _____

All authorized individuals accompanying the minor **MUST** be over the age of 18 and present a photo ID that matches the name listed upon registration of child.

This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to Henry J. Austin Health Center prior to this date.

_____ _____
Signature of Parent/Guardian Parent/Guardian Phone Number

HJAHC

HENRY J. AUSTIN HEALTH CENTER

QUALITY CARE CLOSE TO HOME

Acknowledgment of Notice

I acknowledge receipt of Henry J. Austin Health Center's Notice of Privacy Practices.

_____ _____

Patient's Signature Date

_____

Patient's Name

_____

Medical Record #

Reconocimiento de Aviso

Yo reconozco el recibo del Aviso de Prácticas de Privacidad del Centro de Salud Henry J. Austin.

_____ _____

Firma del Paciente Fecha

_____

Nombre del Paciente

_____

de Expediente Médico

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71