6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

I. Patient Information

First Name:		Middle Name:	
Last Name:		Date of Birth (MM/DD/YYYY):	
Sex Assigned at Birth: ☐ Male ☐ Female		Gender Identity / Pronouns:	
Address:			
City:		State:	
ZIP:		Cell Phone:	
Email: *Required for patient portal access*		Home Phone:	
Preferred Contact Method: ☐ Call ☐ Text ☐ Email			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____			
Preferred Language:		Interpreter Needed:	
Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Other: _____			
Emergency Contact:		Relationship:	
Phone:			
Employer:		Occupation:	
Employer Address:			
Pharmacy Name:		Pharmacy Phone:	
Pharmacy Address / Cross Streets:			

II. Insurance Information

Primary Insurance:		Policy/Group #:	
Cardholder Name:		Insured Date of Birth:	
Relationship to Patient (Self / Spouse / Child / Other):			
Secondary Insurance:		Policy/Group #:	
Cardholder Name:		Insured Date of Birth:	
Relationship to Patient (Self / Spouse / Child / Other):			

Patient Signature: _____ **Date:** _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

III. Medical History

Are you currently being treated for, or have you ever had, any of the following? Check all that apply.

☐ None / no significant history

Heart / Circulation ☐ High blood pressure ☐ High cholesterol ☐ Heart attack ☐ Heart failure ☐ Arrhythmia	**Lungs / Breathing** ☐ Asthma ☐ COPD / Emphysema ☐ Sleep apnea ☐ Tuberculosis	**Musculoskeletal** ☐ Arthritis ☐ Chronic pain ☐ Fibromyalgia ☐ Back / joint issues
Endocrine / Metabolic ☐ Diabetes (Type ☐1 ☐2) ☐ Thyroid condition ☐ Obesity ☐ Osteoporosis	**Neurologic** ☐ Stroke / TIA ☐ Seizures ☐ Migraines ☐ Neuropathy	**Genitourinary** ☐ Kidney disease ☐ Kidney stones ☐ Prostate problems ☐ Urinary incontinence
Digestive ☐ GERD / Reflux ☐ Ulcers ☐ IBS ☐ Liver disease / hepatitis	**Psychiatric** ☐ Depression ☐ Anxiety ☐ Bipolar disorder ☐ ADHD	**Immune / Blood** ☐ Anemia ☐ Cancer ☐ Autoimmune disease ☐ Frequent infections

Infectious Disease / Exposure History

☐ Tuberculosis exposure or positive test ☐ Hepatitis (A / B / C) ☐ HIV / AIDS

Other significant medical conditions / Notes:

Any recent hospitalizations / ER visits (past 12 months)? ☐ No ☐ Yes
If yes, please specify date(s), reason, and facility name

IV. Past Surgeries / Procedures

Please detail past surgeries and include an approximate year if known. ☐ None

_____

_____

_____

Patient Signature: _____ **Date:** _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

V. Allergies & Reactions

☐ No known allergies *If yes, please specify any drug, food or environmental allergen:*

Allergen	Reaction

Allergen	Reaction

VI. Current Medications

List prescription and over-the-counter medications, birth control, supplements or vitamins. ☐ None

Medication	Dose	Frequency

VII. Primary Care Provider & Other Specialists Involved in Your Care

☐ Moukdad Medical - New PCP ☐ Moukdad Medical - Existing / Current PCP

☐ Other PCP provider Name: _____ Phone: _____

Prior PCP Last Visit: _____ Name: _____ Phone: _____

List the other doctors or healthcare providers you see regularly.

Provider Name	Specialty	Phone / Office

☐ I consent to receive appointment reminders or medical information via text or email.

☐ I would like access to my Moukdad Medical patient portal.

☐ I am interested in using telehealth visits when appropriate.

Patient Signature: _____ **Date:** _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

VIII. Preventive Care Snapshot

Test	Have you had this done?	If yes, approx. year	Result / Notes
Annual Physical Exam	☐ Yes ☐ No ☐ Unsure		
Colonoscopy / Stool Test	☐ Yes ☐ No ☐ Unsure		
Mammogram (if applicable)	☐ Yes ☐ No ☐ Unsure		
Pap Smear (if applicable)	☐ Yes ☐ No ☐ Unsure		
Bone Density (if applicable)	☐ Yes ☐ No ☐ Unsure		
Eye Exam	☐ Yes ☐ No ☐ Unsure		
Dental Exam	☐ Yes ☐ No ☐ Unsure		
Hearing Screen	☐ Yes ☐ No ☐ Unsure		
Skin Check / Dermatology Exam	☐ Yes ☐ No ☐ Unsure		
PSA / Prostate screening (if applicable)	☐ Yes ☐ No ☐ Unsure		

Vaccine	Have you had this done?	If yes, approx. year
Tetanus (Td or Tdap)	☐ Yes ☐ No ☐ Unsure	
COVID-19 Vaccine	☐ Yes ☐ No ☐ Unsure	
Flu Shot	☐ Yes ☐ No ☐ Unsure	
Shingles	☐ Yes ☐ No ☐ Unsure	
Pneumonia	☐ Yes ☐ No ☐ Unsure	
RSV	☐ Yes ☐ No ☐ Unsure	
HPV	☐ Yes ☐ No ☐ Unsure	
Other: _____	☐ Yes ☐ No ☐ Unsure	

Patient Signature: _____ **Date:** _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

IX. Family History

Please list any significant conditions such as high blood pressure, diabetes, heart disease, cancer, stroke or other hereditary illnesses. ☐ Unknown / Adopted

Family Member	Condition / Diagnosis	Age of Onset (if known)
Mother		
Father		
Siblings		
Other (Relative): _____		

X. Social History

Please tell us about your daily habits and environment to help us provide more personalized care.

Social Factor	Response
Tobacco Use	☐ Never ☐ Former ☐ Current How much / how often: _____
Alcohol Use	☐ No ☐ Yes How much / how often: _____
Recreational Drug Use	☐ No ☐ Yes Type / Frequency: _____
Exercise	☐ Rare ☐ Occasional ☐ Regular Type / Frequency: _____
Mobility / Assistive Device	☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____
Caffeine	☐ Occasionally ☐ Daily Amount: _____
Living Situation	☐ Live alone ☐ With family/partner ☐ Other: _____
Sleep Quality	☐ Good ☐ Fair ☐ Poor
Stress Level	☐ Low ☐ Moderate ☐ High
Work Environment	☐ Sedentary ☐ Physical ☐ High stress ☐ Other: _____
Advance Directive / Living Will	☐ Yes ☐ No ☐ Unsure

XI. Signature

I certify that the information provided is true and complete to the best of my knowledge.

Patient Signature: _____ **Date:** _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

Federal law (HIPAA) requires that we provide each patient with a Notice of Privacy Practices, which explains how your medical information may be used and disclosed, and how you can access that information.

Please review the statement below and sign to acknowledge receipt or review of this notice.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received (or have been offered) a copy of Moukdad Medical's *Notice of Privacy Practices*.

I understand that this notice explains how my health information may be used and shared for purposes of treatment, payment, and healthcare operations.

I also understand that I may request an additional copy at any time and that Moukdad Medical may revise this notice as permitted by law.

Patient Name: _____

Date of Birth: _____

Patient Signature (or Legal Representative)**:** _____ **Date:** _____

If signed by Legal Representative, state relationship to patient: _____

FOR OFFICE USE ONLY

☐ **Patient refused to sign acknowledgment**
☐ **Notice mailed to patient on:** _____
☐ **Reason patient did not sign:** _____

Staff Initials: _____ **Date:** _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

FINANCIAL POLICY & CONSENT FOR TREATMENT

We are committed to providing you with high-quality medical care and transparent communication regarding your financial responsibilities.

Please review the following policies carefully and sign below to acknowledge your understanding and consent.

CONSENT FOR MEDICAL TREATMENT

I voluntarily consent to receive medical evaluation and treatment from Moukdad Medical and its healthcare providers.

This includes routine diagnostic procedures, physical examinations, and any medically necessary services ordered by my provider.

I understand that I may withdraw this consent at any time by notifying Moukdad Medical in writing.

INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize Moukdad Medical to release any medical information necessary to process my insurance claims and coordinate care.

I authorize my insurance company, Medicare or any third-party payer to release information as needed for claim processing.

I hereby assign and authorize direct payment of medical benefits to **Moukdad Medical** for services rendered.

I understand that:

> I am financially responsible for any balance not covered by insurance, including co-pays, deductibles, and non-covered services.
>
> If my insurance carrier issues payment directly to me, I will promptly remit that payment to Moukdad Medical.
>
> I am responsible for verifying that my insurance coverage is active and current at the time of service.
>
> It is my responsibility to provide accurate insurance information and to notify Moukdad Medical of any changes.

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

CO-PAYS, DEDUCTIBLES, AND BALANCES

Co-pays are due **at the time of service.**

Balances not paid within 30 days of the first statement may be subject to additional billing fees.

If you are uninsured, full payment is expected at the time of service unless prior arrangements are made.

NO-SHOW AND CANCELLATION POLICY

We kindly request **at least 24 hours' notice** for appointment cancellations.

Repeated no-shows or late cancellations may result in a missed appointment fee and/or discharge from the practice.

COMMUNICATION & BILLING NOTICES

You may receive calls, emails, texts or mailed statements related to appointments or billing.

By signing below, you consent to these communications for routine business purposes.

Moukdad Medical will never share your contact information for marketing purposes.

TELEHEALTH SERVICES

I understand that telehealth involves the use of secure electronic communication to provide medical services and consent to participate if recommended by my provider.

PATIENT ACKNOWLEDGMENT

I have read and understand the financial, treatment, and insurance policies of Moukdad Medical.

I understand that I am responsible for payment of all services rendered and agree to comply with these policies.

This authorization will remain in effect until revoked in writing.

Patient Name: _____ **Date of Birth:** _____

Patient Signature (or Legal Representative)**:** _____ **Date:** _____

If signed by Legal Representative, state relationship to patient: _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

NON-DISCRIMINATION & PATIENT RIGHTS STATEMENT

At Moukdad Medical, we are dedicated to providing compassionate, respectful and equitable care to all patients. We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, religion or any other protected characteristic.

YOUR RIGHTS AS A PATIENT

As a patient of Moukdad Medical, you have the right to:

- Be treated with dignity, respect, and consideration at all times.
- Receive care without discrimination or bias.
- Obtain clear information about your diagnosis, treatment options, and expected outcomes.
- Participate in decisions regarding your care.
- Request access to your medical records and request amendments when appropriate.
- Expect privacy and confidentiality of your health information as required by HIPAA.
- Voice concerns or complaints without fear of retaliation or compromised care.

YOUR RESPONSIBILITIES AS A PATIENT

You are encouraged to:

- Provide complete and accurate information about your medical history.
- Follow your provider's treatment plan and notify us of any changes or concerns.
- Treat staff and other patients with respect and courtesy.
- Meet financial obligations related to your care as outlined in the Financial Policy.

NON-DISCRIMINATION & ACCESSIBILITY\

Moukdad Medical provides reasonable accommodations for patients with disabilities and language barriers. If you require assistance, interpretation services, or an auxiliary aid to communicate effectively, please notify our staff so that arrangements can be made.

PATIENT ACKNOWLEDGMENT

I have read and understand the above statement of patient rights, responsibilities and non-discrimination policy.

Patient Name: _____ **Date of Birth:** _____

Patient Signature (or Legal Representative)**:** _____ **Date:** _____

If signed by Legal Representative, state relationship to patient: _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

TELEHEALTH CONSENT FORM

Telehealth involves the use of secure, real-time audio and/or video technology to provide healthcare services when an in-person visit is not possible or necessary. The purpose is to allow communication with your Moukdad Medical provider from a remote location. Before participating in a telehealth visit, please review the following information and sign to acknowledge your understanding and consent.

BENEFITS

- Convenient access to care without travel
- Continuity of care with your established provider
- Timely evaluation, diagnosis, and treatment

RISKS

- Technology interruptions or equipment failure may affect communication or delay care
- Security measures are in place, but data breaches are still a small risk with any electronic system
- In some cases, an in-person evaluation may still be required for a full assessment

PRIVACY & CONFIDENTIALITY

All telehealth sessions are conducted through secure, HIPAA-compliant platforms. Your medical information will be protected in the same way as during an in-person visit.
Moukdad Medical does not permit recording of telehealth visits by either party unless specifically agreed upon in writing.

PATIENT RESPONSIBILITIES

- Participate from a quiet, private location free of distractions
- Ensure your device, camera, and connection are functional
- Not record, broadcast, or share your telehealth session

CONSENT TO TELEHEALTH

I understand the information above and consent to participate in telehealth services with Moukdad Medical.

I understand I may withdraw my consent at any time by notifying the office in writing.

I acknowledge that this consent will remain in effect until revoked.

Patient Name: _____ **Date of Birth:** _____

Patient Signature (or Legal Representative)**:** _____ **Date:** _____

If signed by Legal Representative, state relationship to patient: _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

Patient Portal & Communication Preferences

Moukdad Medical offers a secure online patient portal where you can view visit summaries, lab results and communicate with your care team.

Please complete this form so we can set up or confirm your access and respect your communication preferences.

Patient Name: _____

Date of Birth: _____

Portal Enrollment

☐ I already have a Moukdad Medical portal account.

☐ Please send me an invitation to enroll using the email below.

☐ I prefer not to use the portal at this time.

Email for Portal Access: _____

Test Results & Communication

☐ I am comfortable receiving results and messages through the secure patient portal.

☐ I prefer to discuss results directly with my provider before viewing them online.

☐ Please notify me by phone when new results are available.

Electronic Communication Acknowledgment

I understand that the patient portal is a secure system intended for routine, non-urgent communication.

For emergencies, I will call 911 or go to the nearest emergency department.

I understand that Moukdad Medical may use my phone number, email or patient portal to send appointment reminders, follow-ups and billing information.

Patient Signature: _____ **Date:** _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

CREDIT CARD ON FILE AUTHORIZATION FORM

Moukdad Medical offers the convenience of keeping a credit or debit card on file for payment of balances, co-pays and telehealth services.

All card information is stored securely in compliance with PCI standards.

PURPOSE

Keeping a card on file allows timely payment of any patient-responsible balances after your insurance has processed claims. Your card **will not be charged** until:

- Your insurance company has determined your responsibility for payment, or
- You have agreed to pay for services not covered by insurance, or
- A late-cancellation or no-show fee applies under our Financial Policy.

CARDHOLDER INFORMATION

Name on Card: _____

Billing Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____

Card Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Last 4 Digits: ____ **Expiration (mm/yy):** ____ **CVV:** ___

PATIENT AUTHORIZATION

I authorize **Moukdad Medical** to charge my card for patient-responsible balances, co-pays, telehealth visits, and no-show fees, as applicable.

I understand that:

- I will receive a statement or receipt for any charge made to my card.
- This authorization will remain on file until I provide written notice to cancel it.
- I may update or revoke this authorization at any time by contacting Moukdad Medical.

Cardholder Signature: _____ **Date:** _____

Patient Name: _____ **Date of Birth:** _____

6725 Columbia Avenue
North Bergen, NJ 07047

moukdad MEDICAL

P: 201.422.3111 • F: 201.422.3113
moukdadmedical@gmail.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

According to HIPAA regulations, signed authorization is required before any medical information can be disclosed to anyone other than the patient.

Please be advised that the undersigned patient grants permission for his or her medical information to be discussed with the individuals listed below.

Patient Name: _____

Date of Birth: _____

I hereby authorize Moukdad Medical to discuss and/or release information regarding my medical care, test results, treatment, and billing with the following individual(s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization remains in effect until revoked in writing by the patient. I understand that I may revoke this authorization at any time by submitting a written notice to Moukdad Medical.

I understand that this authorization is voluntary and that treatment, payment or eligibility for benefits will not be conditioned on my decision to sign this form.

Patient Signature: _____ **Date:** _____

Witness / Staff Signature: _____ **Date:** _____