REGISTRATION INFORMATION

Date: _____ (PLEASE PRINT) Home Phone: (____) _____

Patient: _____ Cell Phone: (____) _____
Last Name First Name Middle Initial

Responsible Party (if a minor): _____

Street Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School: _____

Employer/School Address: _____

Occupation: _____ Employer/School Phone: (____) _____

Spouse (or responsible party) Employed by: _____

Business Address: _____

Occupation: _____ Business Phone: (____) _____

Purpose of Visit: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? ☐ No ☐ Yes ► If yes,

Name of Primary Insurer: _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any): _____

Contract # _____ Group # _____ Subscriber # _____

☐ Medicare ☐ Medicaid Claim ID # _____

If Welfare, your number: _____ County of: _____

I prefer to: ☐ Pay my balance in full at time of service. ☐ Pay my balance in full upon receipt of first statement.

☐ Make payment arrangements prior to services being rendered.

In case of emergency, who should be notified? _____ Phone: (____) _____

Your Drugstore Name: _____ Phone: (____) _____

How did you learn of our practice? _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

HEALTH HISTORY

Confidential

Patient Name_____ Today's Date _____

Age_____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear _____

Have you had a mammogram?_____

Are you pregnant? _____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.

_____

_____

_____

_____

_____

Pharmacy Name Phone

ALLERGIES To medications or substances

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family:

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
☐ Arthritis, Gout	
☐ Asthma, Hay Fever	
☐ Cancer	
☐ Chemical Dependency	
☐ Diabetes	
☐ Heart Disease, Strokes	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Tuberculosis	
☐ Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

CONSENT/AUTHORIZATION FORM

Midtown East Family Medicine PLLC
115 East 57th Street
Suite# 1460
New York, N.Y. 10022
TEL: 212-988-8459
License# 205693

Date _____

CONSENT FOR TREATMENT I authorize the above-named doctor(s), to perform the treatment/procedure(s) described below. I have been informed of the reasons for the treatment/procedure(s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following:

_____

_____

_____

_____

_____

The treatment/procedure(s) was explained to me in detail and all my questions were fully answered. Understanding this, I authorize the above-named doctor(s) to perform such examinations, treatments, laboratory tests, and to administer such medications as, in his or her opinion, are necessary or advisable for me (or _____).

Name of patient if minor

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RELEASE OF MEDICAL RECORD In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

INSURANCE AUTHORIZATION I request that payment of authorized benefits be made to the above-named doctor(s) on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original.

Signed _____ Date _____

Patient or person authorized to consent for patient

New Patient Symptom Survey

Patient Name: _____ Date of Birth: _____

COMMON SYMPTOMS: Circle the number according to severity: 0 = NONE, 1 = MILD, 5 = VERY SEVERE

Abdominal Gas or Cramping	0	1	2	3	4	5	Hives	0	1	2	3	4
Arthritis or muscle pain	0	1	2	3	4	5	Hyperactivity	0	1	2	3	4
Asthma	0	1	2	3	4	5	Itching	0	1	2	3	4
Cough	0	1	2	3	4	5	Nasal Congestion	0	1	2	3	4
Eczema	0	1	2	3	4	5	Poor memory or concentration	0	1	2	3	4
Fatigue	0	1	2	3	4	5	Sneezing	0	1	2	3	4
Frequent colds or sore throat	0	1	2	3	4	5	Trouble breathing while sleeping	0	1	2	3	4
Frequent sinus or ear infection	0	1	2	3	4	5	Watery, red, itchy eyes	0	1	2	3	4
Headache	0	1	2	3	4	5	Wheezing	0	1	2	3	4

SYMPTOM SCORE: _____ List any other current symptoms: _____

HISTORY

Are there any foods that cause you any problems? _____ How? _____
Do you have a history of allergies? ( ) Yes ( ) No If yes, how long have you had allergies? _____
What season(s) do your allergies usually flair up? ( ) Spring ( ) Summer ( ) Fall ( ) Winter ( ) All Year
Have you been allergy tested before? ( ) Yes ( ) No If yes, when _____
Does any medication give you relief of your allergy symptoms? ( ) Yes ( ) No Comment: _____
Do you have pets at home? ( ) Yes ( ) No Type: _____ Do they cause symptoms? _____
Are you exposed to fumes or dust? ( ) Yes ( ) No Comment: _____
Do you smoke? ( ) Yes ( ) No How much? _____
Are you exposed to smoke in your environment? ( ) Yes ( ) No
Who else in your family has allergies/asthma? ( ) Mom ( ) Dad ( ) Sibling ( ) Children
Have you been diagnosed with asthma? ( ) Yes ( ) No If so when? _____ Severity: ( ) Mild ( ) Moderate ( ) Hig
Do you think your asthma is under control? ( ) Yes ( ) No
How often are you using your inhaler? _____
Are you taking any sleep aids? _____

CONTRAINDICATIONS

Do you suffer from uncontrolled asthma or reduced lung function? ( ) Yes ( ) No
Ever had a severe allergic reaction? ( ) Yes ( ) No Ever hospitalized due to allergies? ( ) Yes ( ) No
Taking Beta Blockers to treat heart disease: ( ) Yes ( ) No Name of Medication: _____
Have you taken any allergy, antihistamine or cold medicine in the past 72 hours? ( ) Yes ( ) No
Are you pregnant? ( ) Yes ( ) NO ( ) N/A

CLINICAL USE ONLY

Is Patient Recommended for Allergy Test? ( ) Yes ( ) No Date of Allergy Test _____ Skin ( ) Blood ( )
Refer Patient to a specialist ( ) Yes ( ) No
Reviewed by: _____ Provider: _____ Date: _____