Patient Information

Name_____ **Soc.Sec. #** _____
Last Name **First Name** **Initial**

Cell phone _____ **Home Phone** _____

Address_____ **Apt No.**_____

City_____ **State**_____ **Zip**_____

Gender: ☐ **M** ☐ **F** ☐ **Non Binary** **Age** _____ **Birthdate**_____ **Language** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

In case of emergency who should be notified?_____ **Phone** _____

Relationship? _____

E-mail address _____

Patient Employed by_____ **Occupation** _____

Business Address_____ **Business Phone** _____

Primary Doctor _____ **Address** _____

Phone Number_____ **Fax Number**_____

Whom may we thank for referring you?_____

Pharmacy Information

Name of the Pharmacy _____

Address_____
Street **City** **State** **Zip Code**

Telephone number (_____)_____ **Fax number (_____)**_____

Please read the following disclosure carefully. Please note that your prescriptions may be submitted electronically to the pharmacy of your choice. You can change your designated pharmacy at any time. Controlled substances and some other medications that cannot be submitted electronically must be picked up in person (we will not mail, fax, email or call them in).

Signature_____ ***Name***_____ ***Date***_____

by signing this form I certify that I reviewed the above information and that all the above information is correct to the best of my knowledge

NYC MEDICAL AND NEURODIAGNOSTIC, P.C.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand NYC Medical and Neurodiagnostic's Notice of Information Practices. I understand that NYC Medical and Neurodiagnostic may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that NYC Medical and Neurodiagnostic will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in NYC Medical and Neurodiagnostic's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____

_____ _____

Patient or Guardian Signature Date

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name: _____ Relationship: _____

_____

Patient or guardian signature

INSURANCE/PAYMENT AUTHORIZATION FORM

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

Name of Insurance Plan

and assign directly to NYC Medical & Neurodiagnostic, PC, 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. Appropriate efforts will be made by this office to bill my insurance, workman's comp, etc. if applicable, however I understand that co-pays, deductibles, and ultimately the total amount of my bill is my responsibility and I will be expected to settle my account in a timely manner. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize to use of this signature on all insurance submissions and permit copies of this authorization to be used in place of the original. Should any balance remain after 90 days, I will pay interest at the annual rate of 9% (0.75% per month) starting from the date the charges were made. I understand that delinquent accounts are turned over to a collection agency. If this account is assigned to an outside agency for collection, I agree to pay all attorney fees, court costs, and a collection agency fee of 40%, which will be added to the outstanding balance of my account with or without suit. I understand that some services are not covered by my medical insurance (including but not limited to performance and interpretation of medical tests, completion of various medical and/or legal forms, various letters). I will be charged for these services separately but I have a right to receive an estimate of charges prior to the work being performed.

Patient (or responsible party)/ Guardian signature: _____ Date: _____

– Information Consent and Authorization Form –

HIPAA E-mail consent

- HIPAA stands for the *Health Insurance Portability and Accountability Act.* HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information

- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

- Email is a very popular and convenient way to communicate for a lot of people but the federal government provided guidance on email and HIPAA. *The Privacy Rule allows covered health care providers to communicate electronically, such as through e-mail, with their patients, provided they apply reasonable le safeguards when doing so. See 45 C.F.R. § 164.530(c). For example, certain precautions may need to be taken when using e-mail to avoid unintentional disclosures, such as checking the e-mail address for accuracy before sending, or sending an e-mail alert to the patient for address confirmation prior to sending the message."*

- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

- We take Privacy very seriously and we will take every precaution to safeguard your private information

- Please select one of the two options:

OPTION 1 – YES, ALLOW UNENCRYPTED EMAIL I understand the risks of unencrypted email and do hereby give permission to NYC Medical and Neurodiagnostic, P.C. (all providers and staff) to send me personal health information via **unencrypted email**

_____

Signature Date Printed name Please print email address (parent or guardian if patient is a minor)

OPTION 2 – NO, I **DO NOT ALLOW UNENCRYPTED EMAIL** I do not wish to receive personal health information via email

_____

Signature Date Printed name (parent or guardian if patient is a minor)

Patient's Name _____

PATIENT'S PERSONAL HISTORY

Date _____

Confidential Record: Information contained here is kept confidential according to NYC Medical and Neurodiagnostic Notice of Information Practices.

Please answer the following questions focusing on the past 12 months:

ALLERGY/ENDOCRINE/IMMUNOLOGIC/SKIN	Y	N
autoimmune diseases (e.g. Crohn's, Thyroid, Ulcerative colitis, Lupus, Rheumatoid arthritis, Sjogren's, Ankylosing spondylosis)…….……..……..	☐	☐
bleeding or clotting disorders……..…..….	☐	☐
elevated Blood Glucose (sugar), diabetes……..…	☐	☐
hair: unexplained loss/ growth…….....	☐	☐
history of anemia……...	☐	☐
history of rashes……	☐	☐
have you received the Covid-19 vaccine.....	☐	☐

CARDIOVASCULAR		
calf pain on walking that resolves with rest……..…..	☐	☐
elevated Blood Pressure…….....….	☐	☐
elevated cholesterol……..……..……	☐	☐
heart disease or heart attack……..……..	☐	☐
palpitations/ irregular heartbeats…….	☐	☐

GASTROINTESTINAL	Y	N
changes in appetite……..…….….....	☐	☐
constipation / diarrhea / incontinence……..…..	☐	☐
difficulty with swallowing…….……	☐	☐
frequent nausea or vomiting…….	☐	☐

GENERAL HEALTH		
change in weight? Intentional / unintentional……	☐	☐
increasing fatigue or loss of energy.....	☐	☐
perform usual daily activities without difficulty...	☐	☐
recent fevers or unexplained illnesses.....	☐	☐

GENITOURINARY	Y	N
incontinence/ loss of bladder function……..…..	☐	☐
kidney stones…….…….	☐	☐
pain / tingling with urination……..….	☐	☐
Females:		
regular menstrual cycles……..……..……	☐	☐
last period (date)_____		

HEAD/EYES/EARS/NOSE/THROAT	Y	N
change in vision/ partial loss / blurred / double……	☐	☐
dizziness/ Spinning sensation/ lightheadedness…...	☐	☐
fainting or loss of consciousness……..…	☐	☐
headaches……....	☐	☐

MUSCULOSKELETAL	Y	N
drooping of one side of the face/ one eye……	☐	☐
history of back pain: Neck / Mid / Low…….	☐	☐
joints becoming increasingly painful……..….	☐	☐
loss of muscle mass (not due to lack of exercise).....	☐	☐
loss of motion in any joint…….	☐	☐
new onset / increasing neck pain/ stiffness……..	☐	☐
weakness in arms or legs.....	☐	☐

NEUROLOGIC	Y	N
difficulties walking/ change in your gait…….	☐	☐
difficulty with speech/ finding/remembering words..	☐	☐
numbness or tingling……..	☐	☐
seizures or staring spells……..……..	☐	☐
stroke or "mini stroke"……..	☐	☐
tremors……...	☐	☐

PSYCHIATRIC		
changes to memory: short term / long term…….....	☐	☐
history of depression and/or anxiety…….	☐	☐
history of hallucinations……	☐	☐
overall change in your mood……..….	☐	☐

RESPIRATORY	Y	N
coughing up blood/ had blood in the sputum…….....	☐	☐
shortness of breath with activity/ at rest……..….	☐	☐
snoring ……	☐	☐
choking/ coughing in sleep ……	☐	☐

PROBLEM/ PAIN INFORMATION FORM

Nombre
Patient name: _____

Fecha
Date: _____

Como ocurrio el dolor o problema?
How did your pain/problem occur?

_____
_____

Este problema o dolor es relacionado con algun accidente o caida? Si es asi, explique
Is this pain/problem related to the any injury or accident? Are you claiming any case?
If yes explain: _____

Are you claiming any case related to any accident with car, job or at home? **Yes** ☐ **No** ☐
Esta usted reclamando algunt ipo de caso de accidente
Sea de carro, trabajo o en casa?

If this problem related with your job Are you claiming Workers Compensaton? **Yes** ☐ **No** ☐
Es este problema relacionado con un accidente en su
Trabajo, esta reclamando compensacion de trabajo?

Has a claim has been filed with a no-fault carrier? **Yes** ☐ **No** ☐
Esta reclamando caso de accidente de carro?

I certify that the above information is true to the best of my knowledge.
Yo certifico que todo lo anterior mencionado es verdadero para mi conocimiento.

Signature: _____ **Date:** _____
Firma **Fecha**

Patient's Name _____
DOB _____

PAST MEDICAL HISTORY (Do you have now or have you ever had):

- ☐ Diabetes: ☐ type I ☐ type II
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Deep vein thrombosis (DVT)
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS

SURGERIES: List the names and year of any operations which you have had and year:

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY:

Y N

☐ ☐ Do you use tobacco (Cigarettes/ Chew/ Cigars)
If YES: For how many years? _____ How much? _____
If used in the past when did you quit (year)_____

☐ ☐ Do you drink alcohol?
If YES: How much?_____ How often?_____

☐ ☐ Do you use or have you used any recreational drugs?
If YES: name of the drug (s)? _____ Last time used?_____

MEDICATIONS:

Medication Name	Dose	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES:

Name any drugs to which you are allergic and the reaction you had:

_____
_____