Patient Intake Forms

MARK L. SMITH

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Do not complete the form online within your web browser; your data will NOT be saved. Please save it to your computer first, and then fill it out.

Please review the following instructions for successfully completing a fillable PDF form:

- **Before** completing the document **save** the form (PDF format) to a location on your computer. (Example: Desktop or Documents).

  Instructions:

  » **Right click (or control + click on Mac)** on the form and click "Save as"

  » **Save** to your Desktop, Documents, or other desired location.

  » Once you have saved the form to your computer, you are ready to complete the form.

- **Open** the fillable form and complete all fields.

  » Use only the latest version of Adobe Reader to complete fillable PDF forms. Macintosh and Windows versions of the free Adobe Reader are available from Adobe at http://get.adobe.com/reader/.

- After you have completed the form, **save** a final version of the file to your computer.

- When ready, don't forget to **attach** the completed form and **send to your physician's Surgical Coordinator via email or fax** .

- Some forms have a "Submit" button built into the form which will allow you to submit the form via email directly from the form. These forms will automatically be attached to your email when you click the submit button.

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Northwell Health

REGISTRATION FORM

PATIENT INFORMATION

Patient Name:	**Sex:**	**DOB:**	**Marital Status:**
Home Address:	**City:**	**State:**	**Zip:**
Home Phone: / **Cell Phone:**	**Email Address:**		
Preferred Language:	**Race / Ethnicity:**		
Employer Name:	**Work Phone:**		
Employer Address:	**City:**	**State:**	**Zip:**

EMERGENCY CONTACT

Contact Name:	**Relationship:**	**Phone:**
Guarantor Name : (Patients Under 18 or Disabled)	**Relationship:**	**Phone:**

PHYSICIAN INFORMATION

Primary Care Physician:	**Address:**	**City:**	**Phone:**
Referring Physician:	**Address:**	**City:**	**Phone:**

INSURANCE INFORMATION

Primary Insurance Name:	**Policy #:**		**Group #:**	
Address	**City:**	**State:**	**Zip:**	**Phone:**
Insured's Name: / **Relation to Insured:**	**Insured's DOB:**		**Effective Date:**	
Secondary Insurance Name:	**Policy #:**		**Group #:**	
Address:	**City:**	**State:**	**Zip:**	**Phone:**
Insured's Name: / **Relation to Insured:**	**Insured's DOB:**		**Effective Date:**	

PHARMACY INFORMATION

Pharmacy Name:			
Pharmacy Address:	**City:**	**State:**	**Zip:**
Pharmacy Telephone Number:			

AUTHORIZATION TO RELEASE INFORMATION VIA E-MAIL

By providing your e-mail address you agree to receive by e-mail address information about your healthcare, including protected health information.

SIGNATURE OF PATIENT OR AUTHORIZED GUARDIAN _____ *Date:* _____

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PATIENT FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

I understand that **Northwell Health Physicians Partners**, my treating physicians and their respective designees, will use and disclose my health information for all purposes necessary for treatment, payment and heath care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

- **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to Northwell Health. I understand that I am financially responsible for non covered services. I authorize the release of any medical or other information necessary for discharge planning purposes.
- **FINANCIAL LIABILITY:** I have been provided a copy of the Northwell Health Physicians Partners financial policies and agree to the specific terms. I agree to pay all charges (or to become due) to Northwell Health Physicians Partners for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party will be credited on account. I understand that I will be responsible for any charges if any of the following apply:
    - My plan requires prior referral by a Primary Care Physician (PCP) before receiving services at Northwell Health and I have obtained such referral or I receive services in excess of the referral, and/or
    - My health plan determines that the services I receive at Northwell Health are not medically necessary and/or not covered by my insurance plan, and/or
    - My health plan coverage has lapsed or expired at the time I receive services at Northwell Health, and/or
    - I have chosen not to use my health plan coverage, and/or
    - The physician I see does not participate with my health care plan.
- **MEDICARE SIGNATURE ON FILE (Medicare patients only):** I request payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patients Medicare Number:_____ Patient Signature: _____

- **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at Northwell Health; such as, anesthesia, interpretation of cardiac tests, imaging services (e.g. X-rays, Ultrasounds, MRI's) and pathology specimen examination. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payer.
- **CANCELLED OR NO SHOW APPOINTMENTS:** I understand that, based on the policy of individual physician offices, I may incur a cancelation fee if I do not provide the required notice of cancelation, or if I do not keep my appointment and have not canceled.

I have read and understand the Northwell Health Physician Partners financial policies above .

_____ _____
Patient Signature **Date**

_____ _____
Guarantor Signature **Date**

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PATIENT MEDICAL HISTORY

Patient Name:	DOB:

Reason for Visit

Chief Complaint:	
How long have you had this problem:	Is there pain involved? ❑ Yes ❑ No

Medications / Medication Allergies

Please list current medications:
Medication allergies (list drugs and reaction to them):
Please list current vitamins and supplements you are taking:

Pacemaker

Do you have a pacemaker: ❑ Yes ❑ No	If yes, please provide the MAKE and MODEL #:

Hospitalizations

Please list all admissions to the hospital and the reason for admission:

Social History

Do you currently use Tobacco: ❑ Yes ❑ No		If yes, # cigarettes / day:		How many years smoking?
If no, have you ever used Tobacco? ❑ Yes ❑ No		If yes, when did you quit?		If yes, # cigarettes / day:
Do you consume Alcohol? ❑ Yes ❑ No		If yes, please specify how often:		
Have you taken any steroids or prednisone in the last 6 months?	❑ Yes ❑ No	If yes, what did you take?	When?	Frequency / Dosage:

Family History

Please list all illnesses that run in your family:

Healthcare Proxy

Do you have a living will/health care proxy? ❑ Yes ❑ No	If no, would you be interested in receiving information on it? ❑ Yes ❑ No

FOR WOMAN ONLY:

Age at first menstrual period:	Date of last menstrual period:	How many times have you been pregnant?	Age at first pregnancy:

# Miscarriages:	# Terminations:	How many children do you have:	Did you breast feed? ❑ Yes ❑ No	If so, how long?

Have you ever taken birth control pills? ❑ Yes ❑ No	If yes, for how long and when?		Family history of breast cancer? ❑ Yes ❑ No	If yes, relationship to you:	
Past history of breast disease? ❑ Yes ❑ No	If yes, for how long and when?		Any nipple discharge? ❑ Yes ❑ No	If yes, for how long and when?	

Signature of Patient or Authorized Guardian _____ *Date:* _____

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	DOB:

HAVE YOU HAD A HISTORY OF, OR ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? PLEASE INDICATE YES OR NO:

Condition	Response		If Yes, Please Explain
1. Recent fevers, weight loss	❑ Yes	❑ No	
2. Eye problems	❑ Yes	❑ No	
3. Heart or vascular problems:	❑ Yes	❑ No	
a. Heart attack	❑ Yes	❑ No	
b. Congestive heart failure	❑ Yes	❑ No	
c. Chest pain	❑ Yes	❑ No	
d. Heart murmur	❑ Yes	❑ No	
e. Mitral valve prolapse	❑ Yes	❑ No	
f. Phlebitis	❑ Yes	❑ No	
g. Problems with circulation	❑ Yes	❑ No	
h. Problems with heart rhythm	❑ Yes	❑ No	
i. Vascular disease	❑ Yes	❑ No	
j. High blood pressure	❑ Yes	❑ No	
5. Breathing problems:	❑ Yes	❑ No	
a. Asthma	❑ Yes	❑ No	
b. Pneumonia	❑ Yes	❑ No	
c. Tuberculosis	❑ Yes	❑ No	
d. Emphysema or chronic bronchitis	❑ Yes	❑ No	
6. Stomach or Intestinal problems:	❑ Yes	❑ No	
a. Liver disease	❑ Yes	❑ No	
b. Jaundice	❑ Yes	❑ No	
c. Hepatitis	❑ Yes	❑ No	
d. Stomach problems	❑ Yes	❑ No	
e. Ulcers	❑ Yes	❑ No	
f. Hiatal hernia	❑ Yes	❑ No	
g. Bowel Disease	❑ Yes	❑ No	
h. Colitis	❑ Yes	❑ No	
i. Diverticulosis	❑ Yes	❑ No	
7. Kidney, bladder or genital problems:	❑ Yes	❑ No	
a. Prostate disease	❑ Yes	❑ No	
b. Enlarged prostate	❑ Yes	❑ No	
c. Kidney or bladder disease	❑ Yes	❑ No	
8. Problems with muscles or joints	❑ Yes	❑ No	
9. Problems with skin / skin cancer	❑ Yes	❑ No	

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Patient Name:	DOB:

Have you had a history of, or are you currently experiencing any of the following? Please indicate yes or no:

Condition	*Response*		*If Yes, Please Explain*
10. Thyroid problems	❑ Yes	❑ No	
11. Diabetes	❑ Yes	❑ No	
12. Problems with brain or spinal cord:	❑ Yes	❑ No	
a. Stroke	❑ Yes	❑ No	
b. Seizures	❑ Yes	❑ No	
c. Fainting	❑ Yes	❑ No	
d. Migraines	❑ Yes	❑ No	
13. Psychiatric problems:	❑ Yes	❑ No	
a. Depression	❑ Yes	❑ No	
b. Suicide attempt	❑ Yes	❑ No	
14. Bleeding disorders:	❑ Yes	❑ No	
a. Bleeding tendencies	❑ Yes	❑ No	
b. Transfusion reactions	❑ Yes	❑ No	
15. History of any cancer	❑ Yes	❑ No	
15. HIV	❑ Yes	❑ No	

Pain Assessment: On a scale of 0 10, please circle the amount of pain you experience:

0 None	1	2	3	4	5 Moderate	6	7	8	9	10 Severe

Describe the pain (sharp, aching, dull, throbbing, etc.)	
Where on your body is the pain:	When did the pain start:
Is the pain always there or does it come and go:	What makes the pain worse:

Signature of Patient or Authorized Guardian _____ *Date:* _____

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Today's Date: _____
Name: _____ Date of birth: _____
Provider Seen Today:_____

Please answer the following questions to the best of your ability. Circle YES for any of the cancers in your **family.**

The Following Relatives Should Be Considered:

(1st degree) Mother, Father, Brother, Sister, Children,
(2nd degree) Paternal & Maternal Aunts/Uncles, Half Siblings, Nieces/Nephews, Maternal/Paternal Grandparents, (3rd degree) 1st Cousins, Great Aunts/Uncles, Great Grandparents

Cancer History Description	Yes	No	YOURSELF or Relatives (see list above)	Paternal or Maternal?	Age of diagnosis
Have you ever received hereditary cancer genetic testing?					
Have you been diagnosed with breast cancer at any age?					
Has a relative been diagnosed with Breast Cancer before the age of 50 (1st, 2nd degree)					
Have you or a relative been diagnosed with Ovarian Cancer at ANY AGE (1st, 2nd degree)					
Are you Ashkenazi Jewish and have a diagnosis of breast cancer in you or a relative at ANY AGE (1st, 2nd degree)					
Have you or a relative been diagnosed with metastatic breast or metastatic prostate cancer at ANY AGE (1st, 2nd degree)					
Have you or a relative been diagnosed with Pancreatic Cancer at ANY AGE (1st, 2nd degree)					
Three or more of the following on the same side of the family diagnosed at ANY AGE: prostate or breast (1st, 2nd, 3rd degree)					
Have you or a relative been diagnosed with Male Breast Cancer at ANY AGE (1st, 2nd degree)					
Three or more of the following cancers (circle) on one side of family diagnosed at ANY AGE: colon, endometrial, gastric, ovarian, brain, pancreatic, small bowel, hepatobiliary tract, renal, or sebaceous adenomas (Patient, 1st, 2nd & 3rd degree)					
Have you or a relative been diagnosed with Colon Cancer before the age of 50 (1st, 2nd degree)					
Has a relative been diagnosed with Uterine/Endometrial cancer before the age of 50 (1st, 2nd degree)					
Have you been diagnosed with Endometrial/Uterine cancer at or before the age of 64					

Patient Signature: _____ MD signature: -
_____ Date: ___/___/___
Notes:

OFFICE USE ONLY

Patient Meets Criteria for call with Certified Genetic Counselor? Yes ☐ No☐ Patient Accepted call with Certified Genetic Counselor? Yes ☐ No☐
If no, state reason: _____
Patient Tested Yes ☐ No☐ If patient denies, state reason: _____

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PROBLEM / SUMMARY LIST
DIAGNOSIS / SURGERY
ALLERGIES / MEDICATIONS

PATIENT NAME:

DATE OF BIRTH:

- PRIMARY CARE PROVIDER_____PHONE #_____

SIGNIFICANT MEDICAL DIAGNOSES / CONDITIONS	DATE

PREVIOUS MAJOR SURGERIES / PROCEDURES / HOSPITALIZATIONS	DATE

ALLERGIES	REACTION

MEDICATION	DOSE	FREQUENCY	DATE	DATE	DATE	DATE	DATE

:

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Consent to Out-Of-Network Services

NOTICE TO PATIENT REGARDING PROVIDER'S NON-PARTICIPATION STATUS

Not all providers participate with all health insurance plans ("Health Plan"). Dr. _____ does not have a contract with your Health Plan and is considered an "out-of-network provider" or "non-participating provider."

Receiving medical services from a non-participating provider may result in additional out-of-pocket costs to patients. Patients will be responsible for these costs including any coinsurance, deductible and the difference between the charges billed to the Health Plan and the amounts paid by the Health Plan. This balance is commonly referred to as a "balance bill".

The patient may request an estimate of costs for services. This is only an estimate and there may be other charges based on the clinical presentation and the Health Plan benefits.

Patients are responsible to obtain any necessary pre-authorizations or referral letters from their primary care physicians if required by their Health Plans. If services are denied by the Health Plan for failure to obtain such referral or pre-authorization, the patient will be responsible for full charges.

I understand the above and consent to receiving medical and/or surgical services by this non participating provider. I agree to pay for any coinsurance, deductible, balance bill or other patient responsibility amount.

All claim checks received by the patient from the Health Plan must be sent to the Practice within 10 days of receipt to avoid collections.

_____

Patient/Agent/Relative/Guardian* (Signature) Date / Time

_____

Print Name Relationship if other than patient

_____

Telephonic Interpreter's ID # Date / Time

OR

_____

Print: Interpreter's Name and Relationship to Patient

_____

Signature: Interpreter Date / Time

_____

Witness to signature (Signature) Date / Time Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

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Northwell Health®

Authorization for Release of Health Information Pursuant to HIPAA

PATIENT NAME (PRINT)	DATE OF BIRTH
PATIENT ADDRESS (PRINT AND INCLUDE APT#)	TELEPHONE NUMBER
	EMAIL ADDRESS

I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV*-RELATED INFORMATION** only if I place my initials on the appropriate line in Item 8(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol, drug treatment, or mental health related treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. Name and address of health care provider or entity to release this information:

6a. If you are requesting only laboratory results directly from Northwell Health Laboratories, enter "Northwell Health Laboratories" above. Provide the following information and then go directly to Sections 8, 10, 11, 12 and 13 and sign as indicated below item 13.

Ordering Physician's Name: _____
Information to Be Released: Laboratory testing results
Date Of Service: _____/_____/_____

Authorized Recipient:	☐ Patient	☐ Patient's Designee (or parent of unemancipated minor patient) Name of Designee _____ Relationship _____

☐ Consulting Physician: Name: _____ Telephone: (_____) _____
Address: _____

The laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of laboratory results. All questions regarding testing and the results will be answered by the PATIENT'S PHYSICIAN ONLY. Reports will generally be available 4 days after ALL laboratory test result are complete.

Result option (select one) _____ ☐ Mail _____ ☐ Fax _____ ☐ Pick-Up (at any Patient Service Center)

Patient or Representative Initials: _____

Copy 1 – Patient Medical Record
Copy 2 – Patient or Patient's Personal Representative

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Authorization for Release of Health Information Pursuant to HIPAA

7. Name, address, telephone and fax numbers of person(s) or category of person to whom this information will be sent:	
Full Name (Print):	Phone #:
Full Address (Print and include Apt or Suite #):	Fax #:
	Email Address:

8. (a).Specific information to be released:

☐ Medical Record Abstract ☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Designated Record Set ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals and consults.

☐ Other: _____
_____

Include: (Indicate by initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Related Information**

_____ **HIV-Related Information**

8. (b).**Authorization to Discuss Health Information**

☐ By initialing here _____ I authorize _____
Initials Name of individual health care provider

to discuss my health information with the individual listed: _____
Individual Name

9. Reason for release of information: ☐ At request of individual ☐ Other: _____	10. Date or event on which this authorization will expire:
11. Printed name and signature of person signing form:	12. Authority to sign on behalf of patient or relationship to patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____ _____ _____
Patient/Agent/Relative/Guardian* (Signature) Date / Time Print Name Relationship if other than patient

_____ _____
Telephonic Interpreter's ID # Date / Time

OR

_____ _____ _____
Signature: Interpreter Date / Time Print: Interpreter's Name and Relationship to Patient

_____ _____ _____
Witness to signature (Signature) Date / Time Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Internal Use Only - Student Immunization Authorization Consent provided by

Consent provided by: _____ Relationship to Patient: _____

Name of HIM Staff Member who obtained verbal consent: _____ Date Processed: _____

Internal Use Only - For Northwell Health Laboratories Use Only:

Date: ____/____/____; Time: ____:____; Personnel Name: _____; Accession #: _____

VD001 (8/24/17)

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Electronic Communication Consent:

If you choose to request your record via e-mail, Northwell Health asks that you acknowledge and consent to the following:

Unless I specifically request otherwise, e-mails sent to me from Northwell Health will be encrypted to keep them secure during transmission. I understand that most personal e-mail services do not encrypt or otherwise protect e-mails and, therefore, e-mails that I send from my email account may not be protected from inappropriate access by others via hacking or other means. As a result, I understand that if I communicate with my provider using my personal e-mail account, it may not be secure and there is a risk that my health information may be obtained by others not affiliated with my provider. Despite this risk, I authorize my provider to transmit my personal health information via e-mail.

I further acknowledge that e-mails may be inadvertently sent to the wrong address and subject to technical malfunctions. Therefore, I understand that e-mail delivery is not guaranteed and potentially subject to unauthorized disclosure to third parties.

I accept that I or my healthcare provider can terminate e-mail communication services at any time.

I understand that I am responsible for notifying the healthcare provider if I choose to discontinue e-mail communications or if my e-mail address has changed.

Patient/Agent/Relative/Guardian* (Signature)	Date / Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date / Time		
OR			
Signature: Interpreter	Date / Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date / Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Request for Email Communication via Unencrypted Email <u>Only</u>

Northwell strongly discourages communication sent without encryption. In addition to the risks identified above, sending e-mail unencrypted means others may be able to access the information and read it once it is transmitted over the Internet. By signing below and authorizing unencrypted email, I acknowledge the risks to which my information may be exposed.

Patient/Agent/Relative/Guardian* (Signature)	Date / Time	Print Name	Relationship if other than patient