Stony Brook Medicine

# PATIENT REGISTRATION

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Name: (Last, First, MI) | | | |
| Address: | | | |
| City: | State/Province: | Zip: | Country: |
| Mailing Address (if different from above): | | | |
| Home Phone: | Work: | Mobile: | |
| Email: | SSN: | Birth Date: | Sex: M ☐ F ☐ |
| Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown ☐ | | | |
| Race: White ☐ Hispanic ☐ Black/African American ☐ Other Pacific Islander ☐ Other ☐ Asian ☐ Native Hawaiian ☐ American Indian ☐ | | | |
| Ethnicity: Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other ☐ | | Language: | |
| Contact Preferred: Home ☐ Work ☐ Mobile ☐ | | Leave Message: Yes ☐ No ☐ | |
| Allow Appointment Reminder: If Yes, please choose one method Call ☐ Text ☐ No ☐ | | | |
| Primary Care Physician: | Referring Physician: | | |
| Pharmacy Name/Address/Phone: | | | |

## EMPLOYER INFORMATION

| | | | |
|---|---|---|---|
| Employer Name: | Phone Number: | | |
| Address: | | | |
| City: | State/Province: | Zip: | Country: |

## EMERGENCY CONTACT INFORMATION

| | |
|---|---|
| Name: | Relationship to Patient: |
| Phone: | Email: |

**POLICY INFORMATION**

| | | | | |
|---|---|---|---|---|
| Patient is the Insured: | Yes ☐ | No ☐ | (if no complete the Insured fields below) | |
| Insured Name: | | | Relationship to Patient: | |
| Insured Address: | | | | |
| City: | State: | | Zip: | Country: |
| Insured Home Phone: | Work: | | | Mobile: |
| Insured Birth Date: | Insured Sex: M ☐ F ☐ | | | Insured SSN: |
| Insured Employer Name: | | | Insured Employer Phone Number: | |
| Insured Employer Address: | | | | |
| City: | State: | | Zip: | Country: |
| **Primary Insurance** | | | | |
| Policy Number: | Insurance Company Group Name: | | | |
| Effective Date: | Expiration Date: | | | Policy Copay: |
| **Secondary Insurance** | | | | |
| Policy Number: | Insurance Company Group Name: | | | |
| Effective Date: | Expiration Date: | | | Policy Copay: |
| **Tertiary Insurance** | | | | |
| Policy Number: | Insurance Company Group Name: | | | |
| Effective Date: | Expiration Date: | | | Policy Copay: |

Group #_____: Patient Name:_____ MR#:_____ Date:_____

## CLINICAL PRACTICE MANAGEMENT PLAN

Patient's Name: _____
Last First Middle

## RELEASE OF INFORMATION

I hereby authorize and direct Stony Brook Internists, University Faculty Practice Corporations having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

X_____ _____
Signature of Patient or Authorized Representative Date

## UNIFORM ASSIGNMENT

I hereby assign, transfer and set over to Stony Brook Internists, University Faculty Practice Corporations sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care, to cover the cost of care and treatment rendered to myself or my dependent.

In addition, I also assign, transfer and set over to all of the other University Faculty Practice Corporations from which I may require medical care, sufficient monies and/or benefits to which I may be entitled. These other University Faculty Practice Corporations are as follows: Stony Brook Anaesthesiology, Stony Brook Dermatology, Stony Brook Family Medical Group, Stony Brook Internists, New York Spine and Brain Surgery, Neurology Associates of Stony Brook, University Associates of Obstetrics and Gynecology, Stony Brook Preventative Medicine Services, Stony Brook Ophthalmology, Stony Brook Orthopaedic Associates., Stony Brook Children's Services, Stony Brook Psychiatric Associates., Stony Brook Radiation Oncology, Stony Brook Radiology, Stony Brook Surgical Associates, and Stony Brook Urology.

X_____ _____
Signature of Patient or Authorized Representative Date

Account Representative: _____

# NOTICE OF PRIVACY PRACTICES

Purpose of this notice: To describe how your medical information is used, whom it is disclosed to and how you gain access to it.

Stony Brook Community Medical as a healthcare provider is permitted by law to collect, use and disclose your "protected health information" or medical record for the purpose of treatment, payment, internal business operations or as required by law for reporting purposes.

You have certain rights including access to your information and some control over who has access to your information.

Stony Brook Community Medical, PC agrees to abide by the terms of this notice but reserves the right to change the terms at any time. Should we do so, we will notify you in writing.

Use and Disclosure of Protected Health Information (PHI): When you sign a consent form to be treated, your protected health information is used to treat you, to bill you or your insurance company for your care and to make decisions on how to provide healthcare services for you, your family and the community we take care of. Your physician, office staff and others outside of Stony Brook Community Medical i.e. your insurer are allowed access to this information.

Some examples of uses and disclosures of your protected health information are for:

- Treatment by your doctor
- Law enforcement
- Workers compensation
- Appointment reminders
- Payment for your treatment by you or your insurance
- Reporting adverse events of medication or medical devices to the FDA
- Reporting health risks
- Response to legal proceedings
- Organ or tissue donation
- Coroners, funeral directors
- Stony Brook Community Medical to determine if we meet the needs of our patients

Any other uses and disclosures not specified require an authorization, including for marketing purposes and disclosures that constitutes the sale of PHI.

## Patient Rights:

A. You have the right to inspect and to obtain a copy of your protected health information for as long as the group maintains your record.
   *We are permitted by NYS law to charge you a fee of 75 cents per page
B. You have the right to restrict or to limit the use of your protected health information that we use for treatment, payment or operations.
   *Stony Brook Community Medical reserves the right to deny you treatment should you restrict the use of your protected health information for treatment, payment or operations, unless the requested restriction relates to disclosures to a health plan and the Protected Health Information relates to a health care service or item which you have paid for in full and out of pocket.
C. You can restrict the release of your health information to family or friends unless they have your written or verbal permission.
D. You have the right to request an accounting of disclosures made of your health information.
   *Your request must be submitted in writing, specifying dates and time periods as far back as six years from today, as long as the events in question happened after April 12, 2003.
E. You have the right to amend your protected health information.
   *To amend your health information, your request must be given in writing along with a reason for doing so. Your request can be denied if the information originated outside Stony Brook Community Medical, PC.
F. You have the right to request confidential communications as long as it is done in writing
   *For example, you can specify that we only contact you at work, at home or by mail, etc.
G. You have the right to receive notifications whenever a breach of your unsecured PHI occurs.

*If you feel your privacy rights have been violated, you may file a complaint, which will be forwarded to our Compliance Officer.*

# Acknowledgement of Receipt of
# Stony Brook Community Medical's Privacy Practices

I, the undersigned, acknowledge that I have received a copy of Stony Brook Community Medical's Notice of Privacy Practices. Should I have any questions about the policy, I will discuss them with my Physician or the group's *Compliance Officer*.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

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## Authorization for the Release of Patient Health Information to a Second Party

I authorize the release of my Patient Health Information to my
*(Fill in name(s) of all that apply.)*

Spouse, _____ Ph:_____
Family Member, _____ Ph:_____
Friend, _____ Ph:_____
School/College Health Services, _____ Ph:_____
Other, _____ Ph:_____

By signing below, I acknowledge that this authorization is valid until it is revoked by me.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient a minor): _____

Print name of Parent/Guardian: _____

Partners in Primary Care
A LOCATION OF STONY BROOK INTERNIST

267 E Main Street, Building C, Smithtown, NY 11787 Phone: 631-418-8069 Fax: 631-656-0470

## *New Patient Medical History*

Name:_____ Date of Birth:____/___/ ____ Age:____ Sex: _____
How did you hear about our practice?

| **Please briefly state in the box below the reason for your visit** |
|---|
| |

| **Past Medical History** | | | |
|---|---|---|---|
| ***Condition / Disease*** | ***Year Began*** | ***Condition / Disease*** | ***Year Began*** |
| High Blood Pressure | | Other(s): | |
| High Cholesterol | | | |
| Hyper/Hypothyroidism | | | |
| COPD, Emphysema or Asthma | | | |
| Diabetes | | | |
| GERD | | | |
| Depression or Anxiety | | | |
| Heart Conditions | | | |

| **Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures** | | | |
|---|---|---|---|
| ***Operation / Hospitalization / Injury*** | ***Month / Yr*** | ***Operation / Hospitalization / Injury*** | ***Month / Yr*** |
| | | | |
| | | | |
| | | | |

| **Other Physicians and Specialists**<br>*List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc.)* |
|---|
| |

| **Medication/Food Allergies or Intolerances**<br>*<u>List</u> below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)* | | | |
|---|---|---|---|
| ***Medication / Food*** | ***Reaction*** | ***Medication / Food*** | ***Reaction*** |
| | | | |
| | | | |

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| Family Health History | | | | |
|---|---|---|---|---|
| ***Relative*** | ***Living or Deceased*** | ***Current age or age at death*** | ***Cause of Death*** | ***Health Problems*** |
| Father: | | | | |
| Mother: | | | | |
| Brother(s): | | | | |
| | | | | |
| Sister(s): | | | | |
| | | | | |
| Children: | | | | |
| | | | | |

| Health Maintenance | | | | |
|---|---|---|---|---|
| ***Test Performed*** | ***Date*** | | | |
| Lipid (Cholesterol) | | Abnormal? | Yes ☐ | No ☐ |
| Colonoscopy | | Abnormal? | Yes ☐ | No ☐ |
| Mammography | | Abnormal? | Yes ☐ | No ☐ |
| Pap Smear | | Abnormal? | Yes ☐ | No ☐ |
| Bone Density | | Abnormal? | Yes ☐ | No ☐ |
| Dental Exam | | | | |
| Eye Exam | | | | |

| Vaccinations | |
|---|---|
| | ***Date*** |
| Tetanus (Tdap) | |
| Influenza (Annual Flu) | |
| Pneumovax-23 / Prevnar-13 (Pneumonia) | |
| Zostavax / Shingrix (Shingles) | |

| Current Medications | | | |
|---|---|---|---|
| Medication | Dosage | Medication | Dosage |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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267 E Main Street, Building C, Smithtown, NY 11787 Phone: 631-418-8069 Fax: 631-656-0470

| Social, Educational and Work History | |
|---|---|
| Marital Status: | |
| Work Status (circle one): Employed/ Unemployed / Retired / Disabled | Hours worked per week: |
| Do you drink alcohol? | Number of drinks per week? |
| Are you a smoker? | If yes, how many packs per day? |
| Are you a former smoker? | If yes, what year did you quit? |
| Do you exercise? | Duration and Frequency? |

## Review of Systems

*Please mark any **persistent** symptoms you have had in the **past few months.** Read through every section and mark "**no problems**" if none of the symptoms apply to you.*

*General*
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/weakness
- ☐ Fever/chills
- ☐ **No problems**

*Skin*
- ☐ New or change in mole
- ☐ Rash/itching
- ☐ **No problems**

*Breast*
- ☐ Breast pain/lump/nipple discharge
- ☐ **No problems**

*Ears/Nose/Throat*
- ☐ Nosebleeds
- ☐ Trouble swallowing
- ☐ Frequent sore throat, hoarseness
- ☐ Hearing loss/ringing in ears
- ☐ **No problems**

*Eyes*
- ☐ Change in vision
- ☐ Eye pain
- ☐ Eye redness
- ☐ **No problems**

*Cardiovascular*
- ☐ Chest pain/discomfort
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ **No problems**

*Respiratory*
- ☐ Cough/Wheeze
- ☐ Loud snoring/altered breathing during sleep
- ☐ Short of breath with exertion
- ☐ **No problems**

*Gastrointestinal*
- ☐ Heartburn/reflux/indigestion
- ☐ Blood or change in bowel movement
- ☐ Constipation
- ☐ **No problems**

*Genitourinary*
- ☐ Leaking urine
- ☐ Blood in urine
- ☐ Nighttime urination or increased frequency
- ☐ Discharge from penis or vagina
- ☐ Concern with sexual function
- ☐ **No problems**

*Musculoskeletal*
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle/joint pain
- ☐ **No problems**

*Endocrine*
- ☐ Heat or cold sensitivity
- ☐ **No problems**

*Hematologic/Lymphatic*
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ **No problems**

*Neurological*
- ☐ Headache
- ☐ Memory Loss
- ☐ Fainting
- ☐ Dizziness
- ☐ Numbness/tingling
- ☐ Unsteady gait
- ☐ Frequent falls
- ☐ **No problems**

*Allergic/Immune*
- ☐ Hay fever/allergies
- ☐ Frequent infections
- ☐ **No problems**

*Psychiatric*
- ☐ Anxiety/stress/irritability
- ☐ Sleep problems
- ☐ Lack of concentration
- ☐ **No problems**

*Women only*
- ☐ Pre-menstrual symptoms (bloating, cramps, irritability)
- ☐ Problem with menstrual periods
- ☐ Hot flashes/night sweats
- ☐ **No problems**

**Please list any other concerns here:** _____

_____

_____

_____

_____

Stony Brook Medicine

# PATIENT REQUEST FOR DISCLOSURE

I hereby authorize _____ to disclose the following information from my health record

Patient name: _____ Date of birth: _____

Address: _____ Telephone: _____

_____ Medical Record Number: _____

Dates of Treatment being requested: _____

Requested Information:

- ☐ Abstract (subset of records)
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Radiology (X-Ray, MRI,etc.)
- ☐ Cardiac CD
- ☐ Emergency Record
- ☐ Laboratory Testing
- ☐ Consults
- ☐ Cardiac Testing
- ☐ Autopsy Report
- ☐ Pathology Report
- ☐ Endoscopy/Colonoscopy
- ☐ Complete Record

Other (please specify) _____

I understand that this may include **sensitive information** relating to:

Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
Behavioral health services/psychiatric care.
Treatment for alcohol and/or drug abuse.

This information is to be released to: _____

_____

_____

Please send by the following method:

- ☐ Printed copy @ 75 cents per page
- ☐ CD @ $6.50
- ☐ Electronic download @ $6.50
- ☐ e-Mail to _____ @ $6.50
  (print very clearly)

Please note: e-mail is not a secure method of transmission of your health information. Stony Brook Medicine is not responsible for the privacy of information e-mailed at your request.

Signed: _____ Date: _____
(Patient) or (Parent/Legal Guardian)

_____ Date: _____
Health Care Agent – Only if the patient lacks capacity to sign for his/her self

Group #:_____ Name:_____ MR#:_____ Date:_____

**Stony Brook Internists**
**P.O. Box 417978**
**Boston, MA 02241-7978**

## GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary".

★ ★ ★ ★ ★ ★ ★ ★

I have read and understand this information. I understand that my insurance company may deny coverage and request that Stony Brook Internists perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient or Legally Authorized Representative | Print Name | Date |

| _____ | _____ | _____ |
|---|---|---|
| Witness | Print Name | Date |

**Partners in Primary Care**

***Patient Portal***

*The Patient Portal allows you to view parts of your personal health record including results, visit summaries, immunizations and medications and also allows you to request medication refills.*

Patient's First Name: _____

Patient's Last Name: _____

Patient's Date of Birth: _____

Gender: ☐ Male ☐ Female

Patient's Email address: _____

*Security Question*

Patient's Postal code: _____

The invitation for the portal will come to your email from **IQHEALTH.**

☐ Decline Patient Portal