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:

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: _____

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: _____

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: _____

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

Long Island Diabetes & Endocrinology

New Patient Medical History

Name: _____ Date of Birth: ___/___/ ____

Referring Physician: _____

_____ _____

Physician's Phone #_____

Today's Date: ___/___/ ____

In the box below, please briefly state the reason for your visit:

Past Medical History *Check (✓) **ALL** that apply to you:*			
☐ Acid Reflux Disease	☐ Chemical Dependency	☐ High Cholesterol	☐ Pacemaker
☐ Alcoholism	☐ Depression	☐ High Triglycerides	☐ Pneumonia
☐ Anemia	☐ Diabetes	☐ HIV Disease	☐ Polio
☐ Anorexia	☐ Emphysema	☐ Kidney Disease	☐ Prostate Problem(s)
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Psychiatric Care
☐ Asthma/Lung Problems	☐ Glaucoma	☐ Migraine Headaches	☐ Stroke
☐ Bleeding Disorder(s)	☐ Goiter	☐ Miscarriage	☐ Suicide Attempt
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Thyroid Problem(s)
☐ Bulimia	☐ Heart Disease	☐ Mumps	☐ Tuberculosis
☐ Cancer	☐ Hepatitis	☐ Osteoporosis	☐ Ulcers
☐ Cataracts	☐ High Blood Pressure	☐ Osteopenia	☐ Vaginal Infection

Past Surgical Procedures/Hospitalizations/Serious Injuries or Fractures			
Operation/Hospitalization/Injury	***Month/Year***	***Operation/Hospitalization/Injury***	***Month/Year***
Have you ever received a blood transfusion?		If yes, please give approximate date(s):	

Other Physicians and Specialists *Below, list your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc.)*

Medication/Food Allergies or Intolerances *Below, list medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)*			
Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

Pharmacy Information	
Pharmacy Name	Address and Phone Number

Current Medications/Vitamins/Supplements			
Medication	Dosage	Medication	Dosage

Social/Educational/Work History	
Marital Status:	Who do you live with?
Work Status (check one): ☐ Employed / ☐ Unemployed / ☐ Retired / ☐ Disabled	Number of hours worked per week:
Do you drink alcohol?	If yes, number of drinks per week:
Are you a smoker?	If yes, number of packs per day:
Are you a former smoker?	If yes, year that you quit:
Do you currently use recreational drugs?	If yes, what and how often:
Do you drink caffeine?	If yes, number of cups per day:

Family History				
Condition / Disease	***Mother***	***Father***	***Sister***	***Brother***
Diabetes				
Thyroid Disease				
High Blood Pressure				
Stroke				
Breast Cancer				
Ovarian Cancer				
Prostate Cancer				
Colon Cancer				
Osteoporosis				
High Cholesterol/High Triglycerides				
Other (please explain)				

Symptoms:

*Check (☑) **ALL** symptoms that apply to you:*

General
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Excessive Tiredness
- ☐ Discomfort
- ☐ Chills
- ☐ Sweats
- ☐ Loss of Appetite
- ☐ Fever

Gastrointestinal
- ☐ Indigestion/Heart Burn
- ☐ Change in Bowel Habits
- ☐ Diarrhea
- ☐ Excessive Gas
- ☐ Constipation
- ☐ Stomach Pain
- ☐ Nausea
- ☐ Vomiting

Eyes
- ☐ Blurring
- ☐ Eye Pain
- ☐ Double Vision
- ☐ Vision Loss
- ☐ Irritation
- ☐ Intolerance to Light
- ☐ Discharge
- ☐ Swelling

Neurologic
- ☐ Temporary Paralysis
- ☐ Loss of Consciousness
- ☐ Tremors
- ☐ Seizures
- ☐ Numbness/Tingling
- ☐ Headache
- ☐ Dizziness
- ☐ Weakness

Respiratory
- ☐ Shortness of Breath
- ☐ Coughing Up Sputum
- ☐ Cough
- ☐ Wheezing
- ☐ Coughing Up Blood
- ☐ Snoring

Cardiovascular
- ☐ Chest Pain/Pressure
- ☐ Irregular Heart Beat
- ☐ Swelling of Ankles
- ☐ Shortness of Breath
- ☐ Loss of Consciousness
- ☐ Varicose Veins

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Stiffness
- ☐ Arthritis

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Frequent Thirst
- ☐ Increased Hunger
- ☐ Increased Urination

Ears/Nose/Throat
- ☐ Sore Throat
- ☐ Ringing/Buzzing in Ears
- ☐ Difficulty Swallowing
- ☐ Ear Discharge
- ☐ Nosebleeds
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nasal Congestion
- ☐ Earache

Allergic/Immunologic
- ☐ Skin Condition(s)
- ☐ Hay Fever
- ☐ HIV Exposure
- ☐ Enlarged Lymph Nodes
- ☐ Persistent Infection(s)

Psychiatric
- ☐ Depression/Anxiety
- ☐ Suicidal Thoughts
- ☐ Hallucinations
- ☐ Mental Disturbance
- ☐ Memory Loss
- ☐ Paranoia

Genito-Urinary
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Breast Lump
- ☐ Poor Bladder Control
- ☐ Frequent Urination
- ☐ Decreased Sex Drive

Heme/Lymphatic
- ☐ Abnormal Bleeding
- ☐ Excessive Bleeding

Skin
- ☐ Rash
- ☐ Itching
- ☐ Dryness
- ☐ Suspicious Wound(s)

Men Only
- ☐ Erectile Difficulties

Women Only
- ☐ Vaginal Discharge
- ☐ Irregular Periods
- ☐ Absent Period(s)
- ☐ Pelvic Pain

Please list any other concerns here: _____

_____

_____

_____

_____

_____

****I certify that the following information is accurate. I will not hold my physician or any members of his/her staff responsible for any errors or omissions made when completing this form.****

_____ _____

Signature of Patient/Parent/Guardian/Personal Representative Date

_____ _____

Please Print Name of Patient/Parent/Guardian/Personal Representative Date

_____ _____

Reviewed By: Date

Long Island Diabetes & Endocrinology

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

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: _____

If you are not interested in the patient portal, please check below:

☐ Decline Patient Portal