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: _____

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

AD2N538

Stony Brook Medicine
Stony Brook, NY 11794

AGREEMENTS FOR PHYSICIAN PRACTICES

AGREEMENTS FOR PHYSICIAN PRACTICES

Financial Agreement/Guarantee of Payment: I, the undersigned patient or responsible party, agree to be fully responsible for payment to Stony Brook University Hospital/University Faculty Practice Corporations for the care and treatment of the patient whose name appears on this form.

I understand that this includes cost sharing payments to the provider (including any co-payments and deductibles) for care and treatment as required by the patient's health insurance contract and benefits. I understand that the patient is responsible for ensuring that authorizations and approvals are obtained as required by their insurance company. If prior approval is not obtained when required or authorization has been denied, I am fully responsible for all charges that the insurance company does not pay, as may be specified under the provisions of my contract and the extent permitted by law.

I understand that I am responsible to provide accurate information to the provider regarding: contact, demographic, health insurance and other pertinent information required for hospital/professional billing and that I must promptly notify the provider of any changes in this information. I agree to provide any other information reasonably requested by the provider in order to bill for the care and treatment provided.

I understand that if I have any questions about my bills I may call:

- 631-444-4151 for Patient Accounts/Hospital Billing
- 631-444-4800 for CPMP Physicians Billing

Release of Information: I consent to the release of all or part of my health record, including my Social Security number to insurance carriers, government agencies, and other third party payors as needed in order for Stony Brook University Hospital/University Faculty Practice Corporations to obtain reimbursement for my care. I also understand that my Social Security number may be provided to the New York Department of Health in accordance with incidence reporting and other New York State hospital regulatory requirements and to manufacturers of medical devices and the Federal Food and Drug Administration for medical device tracking purposes. I consent to the use and disclosure of my protected health information as necessary to treat my condition, obtain payment for treatment and conduct health care operations.

Release of Information to Primary Care Provider & Uniform Assignment

Release of Information to Primary Care Provider: I authorize Stony Brook University Hospital, and University Faculty Practice Corporations staff to disclose health care-related information to my Primary Care Practitioner (PCP) for the purpose of continuity of my health care. I understand that this will include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection.

Uniform Assignment: I transfer, assign and set over to Stony Brook University Hospital/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 hospitalization and medical care to cover the costs and treatment rendered to myself or my dependent.

English: AD2N538 (4/23)
Spanish: AD2N547 (4/23)

AD2N538

Stony Brook Medicine
Stony Brook, NY 11794

AGREEMENTS FOR PHYSICIAN PRACTICES

The following section ONLY pertains to Medicare patients. Patients signing this form who have Medicare Benefits understand that this information is included for their signature.

MEDICARE

Medicare Assignment of Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf directly to the physician or organization providing medical care. I assign, transfer and set over all benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.

English: AD2N538 (4/23)
Spanish: AD2N547 (4/23)

AD2N538

Stony Brook Medicine
Stony Brook, NY 11794

AGREEMENTS FOR PHYSICIAN PRACTICES

Privacy Acknowledgement

Privacy Acknowledgement: I acknowledge that I have been provided a copy of the Stony Brook Organized Health Care Arrangement-Joint Notice of Privacy Practices and have been advised of how health information about me may be used and disclosed by the facilities listed at the beginning of the privacy notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request additional information explaining special privacy protection that applies in other areas such as HIV-related information, mental health and genetic counseling. I have received the Joint Notice of Privacy Practices as of this date, or at a previous visit, not earlier than April 14, 2003.

I have read this entire document and I understand it. I have been given the chance to ask questions and I understand that I may ask more questions at any time.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

X _____ _____ _____ _____
Signature of Patient (or representative) | Relationship (if other than Patient) | Time | Date

_____ _____
Print Name of Witness | Title or Relationship to Patient

X _____ _____ _____
Signature of Witness | Time | Date

My Signature indicates approval related to my care and treatment by the University Faculty Practice Corporations (UFPCs) listed:

Stony Brook Anaesthesiology, UFPC
Stony Brook Children's Service, UFPC
Stony Brook Dermatology Associates, UFPC
Stony Brook Emergency Physicians, UFPC
Stony Brook Family and Preventive Medicine, UFPC
Stony Brook Internists, UFPC
Neurology Associates of Stony Brook, UFPC
New York Spine & Brain Surgery, UFPC
University Associates in Obstetrics & Gynecology, UFPC
Stony Brook Ophthalmology, UFPC
Stony Brook Orthopaedic Associates, UFPC
Stony Brook Pathologists, UFPC
Stony Brook Psychiatric Associates, UFPC
Stony Brook Radiation Oncology, UFPC
Stony Brook Radiology, UFPC
Stony Brook Surgical Associates, UFPC
Stony Brook Urology, UFPC

English: AD2N538 (4/23)
Spanish: AD2N547 (4/23)

AD2N538

Stony Brook Medicine
Stony Brook, NY 11794

AGREEMENTS FOR PHYSICIAN PRACTICES

Documentation of Interpreter or Special Assistance

An interpreter or special assistance was used to obtain consent from this patient as follows:

☐ Foreign Language *(specify)* _____

☐ Sign Language

☐ Visually Impaired

☐ Other (specify) _____

Interpretation or special assistance provided by _____
(Fill in name of interpreter and title or relationship to patient)

X _____ _____ _____
Signature of Witness | Time | Date

Verbal Consent

When verbal consent is given, whether by telephone or in person, the person giving consent/agreement/acknowledgement or refusal clearly states their name, date of birth and relationship to the patient. This is documented clearly on the general consent and agreements form.

I _____, verify my name as stated. My address is _____, _____.
(Name) *(Street Address)* *(City, Village, Hamlet)*

My phone number is _____, my date of birth is _____, and my relationship to the patient is _____.

Further, all verbal consent, whether by telephone or in person is witnessed by two staff members working at any of the campus locations of Stony Brook Hospital.

_____ X _____ _____ _____
Print Name of Witness 1 | Signature of Witness 1 | Time | Date

_____ X _____ _____ _____
Print Name of Witness 2 | Signature of Witness 2 | Time | Date

English: AD2N538 (4/23)
Spanish: AD2N547 (4/23)

PP2C697

Stony Brook Medicine

Stony Brook, NY 11794

GENERAL CONSENT FOR TREATMENT FOR AMBULATORY PRACTICES

My signature below indicates my agreement and understanding of:

1. **General Consent for Treatment:** I consent for _____ (practice name) and its staff, physicians and other practitioners (collectively, the "Practice") to provide and perform such medical care, tests, procedures and other services that are needed or helpful by the Practice for my health and well-being. I understand that this consent will be in effect for one year.

2. **Telehealth Services:** I understand that I may elect to receive certain services via Telehealth and I should inform my practitioner if I am interested in this option.

3. **Responsibility for Patient Care:** I understand that a practitioner is responsible for my care and that he/she may assign doctors, practitioners and staff as deemed appropriate to provide care to me. I also understand that, since the Practice is a teaching site, medical, nursing, social work and other students may observe or assist in my care under the direction of my practitioner and other staff members.

4. **Photographs/Video/Voice Recordings:** I understand that photographs, video and/or voice recordings (the "Recordings") may be taken of me and used for medical purposes such as documenting or planning my care or for quality assurance or education purposes. I understand that the photographs, videos and/or voice recordings taken to document my care are part of my medical record and those taken for other purposes are not part of my medical records. To the extent that such Recordings identify me, I understand that they shall receive the same confidentiality protections as my other health information.

I have carefully read and fully understand this consent form and have had all my questions answered.

Patient's Signature: X _____ 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