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: _____

SOUTHOLD FAMILY MEDICINE | TODAY'S DATE: _____

PLEASE PRINT AND COMPLETE ALL ENTRIES

FAMILY STRUCTURE:
Who do you live with?

COMMUNICATION NEEDS: ☐ None
☐ Deaf ☐ Mute ☐ Blind ☐ Cognitive
☐ Other:

PRIMARY CAREGIVER (Name/Relationship)

☐N/A

LEGAL GUARDIAN (Name/Relationship)

☐N/A

ADVANCED DIRECTIVES/HEALTH CARE PROXY

☐Yes
☐No (please see reception for forms)
☐Decline

BARRIERS TO CARE: ☐None ☐ Transportation ☐ Housing ☐ Live Alone ☐ Ambulation ☐ Financial ☐Insurance ☐ Lack of Support ☐ Difficulty Reading or Understanding Instructions
☐ Other:

OTHER MEDICAL PROVIDERS (Name/Phone)

PREVIOUS PRIMARY DOCTOR

ALLERGIES

☐**None**
☐Medications**:** _____

☐Food**:** _____

☐Other:_____
_

IMMUNIZATION HISTORY

If known, Insert dates of your last immunization against:

Influenza (Flu) _____ Pneumonia _____TDAP (tetanus) _____Hepatitis: _____

MEDICAL HISTORY: Have you ever had any of the following?

- ❑ allergies
- ❑ anemia
- ❑ arthritis conditions
- ❑ arterial fibrillation
- ❑ asthma
- ❑ bleeding problems
- ❑ blood clots
- ❑ coronary artery disease
- ❑ cancer
- ❑ cardiac arrest
- ❑ celiac disease
- ❑ chest pain
- ❑ congestive heart failure
- ❑ chronic fatigue syndrome
- ❑ depression
- ❑ diabetes
- ❑ drug/alcohol abuse
- ❑ erectile dysfunction
- ❑ fibromyalgia
- ❑ GERD
- ❑ heart attack
- ❑ high cholesterol
- ❑ hepatitis
- ❑ high blood pressure
- ❑ hypothyroidism
- ❑ insomnia
- ❑ irritable bowel syndrome
- ❑ kidney problems
- ❑ migraines/headaches
- ❑ neuropathy
- ❑ osteoporosis
- ❑ prostate problems
- ❑ seizure disorders
- ❑ sinus conditions
- ❑ stroke
- ❑ tremors
- ❑ tick related disease

Last Colonoscopy: _____
Result: ☐ Normal ☐ Abnormal

❑**Other:**

FAMILY HISTORY: Please indicate (X) if any of your immediate relatives have had any of the following:

	MOTHER	FATHER	SIBLING (Brother/Sister)
Cancer ☐			
Diabetes ☐			
Heart Attack ☐			
Heart Disease ☐			
Hypertension ☐			
Mental Health ☐			
Substance Abuse ☐			
Stroke ☐			
Thyroid Disease ☐			
Other: ☐			

SURGICAL HISTORY: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	HOSPITAL

OB-GYN HISTORY

Last menstrual period: _____ ☐ Regular ☐ Irregular **Last Pap-Smear**:_____ Result: ☐ Normal ☐ Abnormal
Number of pregnancies: _____ Alive ____ Miscarriages ___ Abortions ____
Last mammography: _____ Result: ☐ Normal ☐ Abnormal
Last Bone density: _____Result: ☐ Normal ☐ Abnormal

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No Quantity ____ oz **Frequency:** ☐ Daily ☐ Weekly ☐ Monthly ☐ Recovery	**Do you use tobacco/nicotine? ☐Yes ☐No** ☐ Smoke (____ cigarettes per day) ☐ Chew ☐ 2nd Hand Smoke ☐ E-cigarettes
Drug Use: ☐ Yes ☐ No If **YES**, what substances:	**Oral Health:** When was your last dental exam: _____ If you have any dental problems, please specify:

MEDICATIONS: List any medications you are currently taking, including over the counter medications and herbal supplements **(or provide a recent list we can copy)**

MEDICATION	DOSAGE/FREQUENCY	MEDICATION	DOSAGE/FREQUENCY

PERSONAL HEALTH GOALS

A health goal/s I would like to work on:

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)

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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
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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)
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AD2N538

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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)

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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: _____

Southold Family Medicine

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