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

SOUTHOLD INTERNAL 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)	**LEGAL GUARDIAN (Name/Relationship)**	**ADVANCED DIRECTIVES/HEALTH CARE PROXY**
☐N/A	☐N/A	☐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	❑ chest pain	❑ hepatitis	❑ sinus conditions
❑ anemia	❑ congestive heart failure	❑ high blood pressure	❑ stroke
❑ arthritis conditions	❑ chronic fatigue syndrome	❑ hypothyroidism	❑ tremors
❑ arterial fibrillation	❑ depression	❑ insomnia	❑ tick related disease
❑ asthma	❑ diabetes	❑ irritable bowel syndrome	Last Colonoscopy: _____
❑ bleeding problems	❑ drug/alcohol abuse	❑ kidney problems	Result: ☐ Normal ☐ Abnormal
❑ blood clots	❑ erectile dysfunction	❑ migraines/headaches	❑**Other:**
❑ coronary artery disease	❑ fibromyalgia	❑ neuropathy	
❑ cancer	❑ GERD	❑ osteoporosis	
❑ cardiac arrest	❑ heart attack	❑ prostate problems	
❑ celiac disease	❑ high cholesterol	❑ seizure disorders	

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:

Southold Internal 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