



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 <input type="checkbox"/> F <input type="checkbox"/>
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown <input type="checkbox"/>			
Race: White <input type="checkbox"/> Hispanic <input type="checkbox"/> Black/African American <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> American Indian <input type="checkbox"/>			
Ethnicity: Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Other <input type="checkbox"/>			Language:
Contact Preferred: Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile <input type="checkbox"/>			Leave Message: Yes <input type="checkbox"/> No <input type="checkbox"/>
Allow Appointment Reminder: If Yes, please choose one method Call <input type="checkbox"/> Text <input type="checkbox"/> No <input type="checkbox"/>			
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 <input type="checkbox"/>	No <input type="checkbox"/>	(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 <input type="checkbox"/> F <input type="checkbox"/>		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

Patient: _____ DOB: _____ Date of Service: _____
Referring MD: _____ Primary MD: _____ Medication Allergies: _____
Chief Complaint: _____

Environmental History

Home: Age ____ Years There ____ Own ☐ Rent ☐
Dusty: Yes ☐ No ☐ Mildew: Yes ☐ No ☐ Recent Floods: Yes ☐ No ☐
Pets: Yes ☐ No ☐ Dogs ____ Cats ____ Birds ____ Hamsters ____ Ferrets ____ Rabbits ____ Other ____
Which allowed in bedroom? _____ On bed? _____
How long has each animal been in the house? _____
Carpeting: Patient's bedroom? Yes ☐ No ☐ Family room? Yes ☐ No ☐
Heating System: Delivered by: Hot water baseboard ☐ Steam ☐ Forced hot air ☐
Air Conditioning: Yes ☐ No ☐ Central ☐ Patient's bedroom? ☐
Times per Month Used: Fireplace ☐ Woodburning stove ☐
Pillows: Foam ☐ Feather ☐ Dacron-Polyester ☐
Blankets: Wool ☐ Acrylic ☐ Down ☐ Velux ☐ Cotton ☐ Poly ☐ Stuffed animals on bed? _____
Basement: Yes ☐ No ☐ Damp or Dry _____ Dehumidifier used? _____
In the basement you do: Laundry ☐ Exercise ☐ Workshop ☐

Review of Systems

Check off any problems you have had repeatedly in the six weeks:

Eyes	Respiratory	Psychiatric
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Cough	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Tearing	<input type="checkbox"/> Sputum	<input type="checkbox"/> Depression
<input type="checkbox"/> Vision Change	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Sleep Disturbances
	<input type="checkbox"/> Wheezing	
Cardiovascular	Gastrointestinal	
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Constipation
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Stomach Pain
Ear, Nose and Throat	Neurological	Gynecologic/Genitourinary
<input type="checkbox"/> Earaches	<input type="checkbox"/> Headaches	<input type="checkbox"/> Urinary
<input type="checkbox"/> Sinus	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Numbness	
<input type="checkbox"/> Snoring		
<input type="checkbox"/> Nasal Congestion		
<input type="checkbox"/> Runny Nose		
Musculoskeletal	Skin	
<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Rashes	
<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Itchy	
None of the above <input type="checkbox"/>		

ROS reviewed: ☐ Signature: _____

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