Patient History

Name:___________________________ Age: ____________________________ DOB:____________________________

Reason for Visit:____

Preferred Pharmacy:________________________________ Located:____

Primary Care Physician:______________________________ Date of Today's Visit:________________________________

Allergies:	**Reaction:**

Current Medications/Supplements:

Last Mammogram: ________________ Last Colonoscopy: ________________ Last Bone Density: ____________________

Menstrual History

1st Day of Last Period: _______________________________ Age at Last Period (if menopausal): ___________________

Are your periods regular? ___________________________ Age at Time of Very 1st Period: _______________________

Period flow is: Mild □ Moderate □ or Heavy □ Cramping is: Mild □ Moderate □ or Heavy □

How long does it last? ____

How many days apart are your menstrual cycles starting from the first day of one cycle to the first day of your next cycle? ____

GYN History:

When was your last Pap smear? _____________________ Last GYN provider: _________________________________

Have you ever had an abnormal Pap smear? □ *No* □ *Yes* When? ____

What abnormality? ____

Have you ever been diagnosed with HPV? _____________ Have you had the **Gardasil** vaccinations? ______________

Are you currently sexually active? □ *Yes* □ *No* □ *Never*

Do you have any concern regarding intercourse (e.g. pain, vaginal dryness, etc.) ________________________________

Would you like to have STD testing performed today? ____

Have you ever been treated for:

□ *Chlamydia* □ *Gonorrhea* □ *Genital Warts* □ *Herpes* □ *Trichomonas* □ *Syphilis* □ *Other* ____________________

Are you currently using birth control? □ *No* □ *Yes* □ *Trying to get pregnant*

Current birth control: _______________________________ Are you satisfied with it: □ *Yes* □ *No*

Do you have a history of infertility? __________________ Infertility treatment? _______________________________

Please List ALL Pregnancies:

Year:	Vaginal/Caesarean	Comments/Complications:

Please List ALL Medical History/Major Illness:

Please List ALL Surgical History:

Family History:

Disease	Mother	Father	Sister	Brother	Mat*GM	Mat*GF	Pat*GM	Pat*GF	Other
Clotting Disorder									
Blood Clots									
Stroke									
Colon Polyp									
Diabetes: 1									
Diabetes: 2									
Heart Disease									
Thyroid Disease									
Mental Illness									
Breast CA									
Breast CA before age 50									
Ovarian CA									
Uterine CA									
Colon CA									
Pancreatic CA									
Other CA									
□ I do not know much about my family history/adopted									

Social History:

Do you live with a partner? ___________________________

Do you feel safe at home? ____________________________

Occupation: ____

Language: ____

Married □ *Single* □ *Divorced* □ *Widowed* □

Significantly Involved □ *Domestic Partner* □

Exercise: *Yes* □ *No* □ How often: _____________________

Type: ____

Special Diet: *Yes* □ *No* □ Type: ______________________

Habits:

Smoking: *Yes* □ *No* □

Packs/day: ________________ Years: _________________

Quit when: ____

Alcohol: *Yes* □ *No* □

Drinks/day: ______________ Drinks/week: _____________

Quit when: ____

Drug use: *Yes* □ *No* □

Type: _____________________ Years: _________________

Quit when: ____

Caffeine: *Yes* □ *No* □ Cups per day: __________________

Breast Cancer Risk Screening:

*Please complete if you are 35 years of age or above

Do you have a medical history of any breast cancer or of ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS) or have you received previous radiation therapy to the chest for treatment of Hodgkin lymphoma?

____

Do you have a mutation in either the *BRCA1* or *BRCA2* gene, or a diagnosis of a genetic syndrome that may be associated with elevated risk of breast cancer? ____

Age? ___________________________

Age at time of 1st period? _______________________

Age at time of 1st child birth? ________________________________

How many first-degree relatives of yours – mother, sisters, daughters – have had breast cancer?

____

Have you ever had a breast biopsy? ____________________________ How many? ____________________________

Have you had at least one breast biopsy with atypical hyperplasia? ____

Race/Ethnicity:

□ *White* □ *African American* □ *Hispanic* □ *Asian-American* □ *Native American or Alaskan Native* □ *Unknown*

Sub Race/Ethnicity:

□ *Chinese* □ *Japanese* □ *Filipino* □ *Hawaiian* □ *Other Pacific Islander* □ *Other Asian-American*

Depression Screening:

*How often have you been bothered by the symptoms listed below?

1. Feeling down, depressed and/or hopeless?

Not at all □ / Several days □ / More than half the days □ / Every day □

2. Little interest / pleasure in activities?

Not at all □ / Several days □ / More than half the days □ / Every day □

3. Trouble falling / staying asleep?

Not at all □ / Several days □ / More than half the days □ / Every day □

4. Tired with little energy?

Not at all □ / Several days □ / More than half the days □ / Every day □

5. Poor appetite / overeating?

Not at all □ / Several days □ / More than half the days □ / Every day □

6. Feeling bad about yourself?

Not at all □ / Several days □ / More than half the days □ / Every day □

7. Trouble concentrating?

Not at all □ / Several days □ / More than half the days □ / Every day □

8. Moving or speaking slowly?

Not at all □ / Several days □ / More than half the days □ / Every day □

9. Thoughts of being better off dead / harming yourself?

Not at all □ / Several days □ / More than half the days □ / Every day □

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 University Associates in Obstetrics & Gynecology, 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 University Associates in Obstetrics & Gynecology, 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: _____________________________________

PA 6a
(4/13-eb)

Group #:__________ Name:________________________ MR#:____________ Date:___________

University Associates in Obstetrics & Gynecology
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 University Associates in Obstetrics & Gynecology 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

Date: ___________________________

Medical Record #: _________________

File#: ___________________________

FINANCIAL AGREEMENT

I/We hereby agree as follows:

1. Guarantee of Payment. Medical care has been or will be provided to the patient whose name appears below. I/We, both jointly and individually, shall be fully responsible for payment of the patient's bill, based on the charges incurred which I/We nowagree are fair and reasonable. The University Faculty Practice Corporations may demand full payment of the patient's bill at any time, but the University Faculty Practice Corporations are not required to do this. Even if the University Faculty Practice Corporations do not demand immediate payment, my/our obligation to make such payment remains the same.

2. When the Patient's Insurance Coverage is Insufficient. If any insurance coverage which the patient may have, such as Blue Shield, Medicare, Medicaid, Compensation or other coverage, rejects the patient's claim or allows only part of the claim, I/we shall be responsible for immediate payment of the balance due to the extent permitted by law.

3. The Agreement. I/We have read and understood this Agreement and have received a copy as well.

____
Name of Patient

____
Name of Person Guaranteeing Payment

____
Signature of Person Guaranteeing Payment

____
Home Address

____
Telephone Number

____
Employer's Name

____

UNIVERSITY FACULTY PRACTICE CORPORATIONS

____

_____________ _______________

____

____
Witness

Stony Brook Medicine

PATIENT REQUEST FOR DISCLOSURE

I hereby authorize ______________________________ to disclose the following information from my health record

Patient name: ____ Date of birth: ______________________

Address: ____ Telephone: ________________________

____ Medical Record Number: ____________

Dates of Treatment being requested: ____

Requested Information:

☐ Abstract (subset of records)
☐ Discharge Summary
☐ Operative Report
☐ Radiology (X-Ray, MRI,etc.)
☐ Cardiac CD
☐ Emergency Record
☐ Laboratory Testing
☐ Consults
☐ Cardiac Testing
☐ Autopsy Report
☐ Pathology Report
☐ Endoscopy/Colonoscopy
☐ Complete Record

Other (please specify) ____

I understand that this may include **sensitive information** relating to:

Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
Behavioral health services/psychiatric care.
Treatment for alcohol and/or drug abuse.

This information is to be released to: ______________________________________

____

____

Please send by the following method:

☐ Printed copy @ 75 cents per page
☐ CD @ $6.50
☐ Electronic download @ $6.50
☐ e-Mail to __________________________________ @ $6.50
(print very clearly)

Please note: e-mail is not a secure method of transmission of your health information. Stony Brook Medicine is not responsible for the privacy of information e-mailed at your request.

Signed: ____ Date: ____________
(Patient) or (Parent/Legal Guardian)

____ Date: ____________
Health Care Agent – Only if the patient lacks capacity to sign for his/her self