CROSS PARK MEDICAL,PLLC

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Internal Medicine, Pulmonary Disease, Geriatrics

NEW PATIENT REGISTRATION FORM, YEAR 2018

(Please print)

Today's Date: / /	Date of your appointment: / /	Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Date of birth: / /	Age:	Sex: ☐ M ☐ F

Name you preferred to be called:	Social Security no:	Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐ Partn

Race: ☐ White ☐ Black ☐ Amer. Indian ☐ Asian ☐ Hawaiian ☐ Other	Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Decline to answer

Home ph no:	Cell ph no:	Email:	Preferred contact method: ☐ Home ph ☐ Cell ph ☐ Email

Street address:	City:	State:	ZIP Code:

Preferred pharmacy name: Pharmacy address: Pharmacy phone no:	**How did you hear about us?** ☐ Facebook ☐ Insurance Company/plan ☐ Our Website ☐ Internet search ☐ Friend/Family ☐ Dr. ___________ ☐ Other: ___________________

Employer:	Employer/Work phone no:	Occupation (if student please specify):

Spouse/Partner Name:	Spouse/Partner Sex: ☐ M ☐ F ☐ Other: ___________

FINANCIAL INFORMATION

If you are under 18, person responsible for bill:	Birthdate: / /	Address (if different):	Home phone no: ( )

Is this person a patient here? ☐ Yes ☐ No

Employer:	Employer/Work phone no:	Occupation (if student please specify):

INSURANCE INFORMATION

(Please give ... st)

Primary Insurance Company:

Subscribers name:	Subscribers S.S.no:	Birthdate: / /	Policy no:	Group no:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________

Name of secondary insurance:	Subscriber's name/Date of birth:	Policy no:	Group no:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________

IN CASE OF EMERGENCY

Name of local friend or relative to contact in an emergency:	Relationship to patient:	Home phone no: ( )	Cell phone no: ( )

CROSS PARK MEDICAL, PLLC

280 West 81st Street, New York, NY 10024

Tel. No: 212-873-1840 Fax: 212-724-6158

PATIENT QUESTIONNAIRE

Name: _____ **Date:**__/__/_____

INSTRUCTIONS: This questionnaire will help your doctor better understand problems that you may have. Your doctor may ask you more questions about some of these terms. Please make sure to check a box for every item.

During the PAST MONTH, have you OFTEN been bothered by ...

	YES	NO
1. Back pain?	☐	☐
2. Pain in your arms, legs or joints?	☐	☐
3. Menstrual pain/problems?	☐	☐
4. Irregular periods?	☐	☐
5. Pain or problems during sexual intercourse?	☐	☐
6. Headaches?	☐	☐
7. Chest pain?	☐	☐
8. Dizziness?	☐	☐
9. Fainting Spells?	☐	☐
10. Feeling your heart pound or race?	☐	☐
11. Shortness of breath?	☐	☐
12. Constipation, loose bowels or diarrhea?	☐	☐
13. Need to get up at night to urinate regularly?	☐	☐
14. Nausea, gas or indigestion?	☐	☐
15. Feeling tired or low energy?	☐	☐
16. Trouble sleeping?	☐	☐
17. The thought that you have a serious, undiagnosed disease?	☐	☐
18. Your eating being out of control?	☐	☐
19. Little interest or pleasure in doing things?	☐	☐
20. Feeling down, depressed or hopeless?	☐	☐
21. Nerves, or feeling anxious or on edge?	☐	☐
22. Worrying about a lot of different things?	☐	☐
23. Have you had an anxiety attack, unreasonable feeling of fear or panic?	☐	☐
24. Thoughts you should cut down on your drinking of alcohol?	☐	☐
25. Anyone complaining about your alcohol use?	☐	☐
26. Feeling of guilt or anger about your drinking?	☐	☐

Overall, would you say your health is:
(Please choose one)

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Other pertinent health information:

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CHECK PAST ILLNESSES:

	AGE		AGE		AGE
ADD/ADHD	____	Diabetes	____	Rheumatologic Disease	____
Anemia	____	Depression	____	Seizures	____
Anxiety	____	Emphysema	____	Stroke	____
Arthritis	____	Erectile Dysfunction	____	Substance Abuse	____
Asthma/Allergies	____	Fibromyalgia	____	Other (Please specify below):	
Atrial Fibrillation	____	Gallstones	____	_____	
Blood Clot	____	Gout	____	_____	
High Blood Pressure	____	Heart Attack	____	_____	
Cancer	____	Heartburn/Reflux	____	_____	
High Cholesterol	____	Kidney Disease	____	_____	
COPD	____	Liver Disease	____	_____	

Number of pregnancies?_____ Number of live births?_____ Number of living children?_____ Pregnancy complications?_____

Serious injuries, illnesses or hospitalizations (Age):_____

_____

Operations:(Age)_____

Last Pap:_____ Abnormal Pap tests: Y N Last Mammogram:_____ Contraception(Type): _____

Immunizations: (Date) Tetanus_____ HPV_____ Pneumonia_____ Shingles_____ Hepatitis B_____ Meningitis_____

Recent medications and dosages (include laxatives, antacids, aspirin):_____

_____

Allergies (medications, pollens, foods, etc.):_____

How often do you exercise?_____ How long do you exercise?_____ What are your hobbies?_____

How is your sleep?_____ How is your diet?_____

Alcohol (average # of drinks per day):_____ Recreational drug use(include type & age):_____

Have you ever smoked? Y N How long?_____ How Much?_____ Tried to stop smoking? Y N Quit Date:_____

Birthplace: _____ Places you have lived and traveled:_____

Education (Highest level completed; special studies)_____

Special problems related to home or work conditions:_____

Check if anyone in your family has ever had the following:

	Relationship		Relationship		Relationship
☐ Diabetes	_____	☐ Stroke	_____	☐ Gout	_____
☐ High Blood Pressure	_____	☐ Migraine Headaches	_____	☐ Asthma	_____
☐ Anemia	_____	☐ Obesity	_____	☐ Arthritis	_____
☐ Heart Disease	_____	☐ Thyroid Disease	_____	☐ Mental Illness	_____
☐ Cancer(type)	_____	☐ Elevated Cholesterol	_____	☐ Allergies	_____
☐ Bleeding Disorder	_____	☐ Kidney Disorder	_____	☐ Other	_____

	IF LIVING		IF DECEASED			IF LIVING		IF DECEASED	
	Age	State of Health	Age	Cause		Age	State of Health	Age	Cause
Mother	___	_____	___	_____	Sister	___	_____	___	_____
Father	___	_____	___	_____	Husband/wife	___	_____	___	_____
Brother(s)	___	_____	___	_____	Children	___	_____	___	_____

If you need more space, please use back side

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RIGHTS AND RESPONSIBILITIES

YOU HAVE A RIGHT:

- To be treated with respect, consideration and dignity always.
- To receive assistance in a responsible manner
- To receive information about your health including your diagnosis, treatment, testing or procedures and medical alternatives including associated risks that may be involved in your healthcare.
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of the alternative and likely consequences of your decision.
- To express a complaint to the Administrator, and/or Physician.

YOU HAVE A RESPONSIBILITY:

- To review and understand your health insurance coverage and benefits.
- To learn and understand the proper use of your insurance plan services and procedures for obtaining coverage. This includes knowing the referral policy for your plan, laboratory restrictions and outpatient facilities covered by your plan as well as co-pay requirements.
- To always carry your insurance plan identification card and be prepared to show it at each visit, if asked.
- Patients will be required to pay for all services provided if insurance information is not provided by the patient at the time services are rendered or the information provided is inaccurate.
- To treat all office personnel respectfully and courteously.
- To keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep an appointment.
- To pay all charges for co-payments, deductibles, non-covered benefits or services at the time of your visit, unless prior arrangements have been made.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of your medical provider and consider the alternatives and/or likely consequences if you refuse to comply.
- To provide honest and complete information to those providing medical care.
- To express your opinions, concerns, or complaints in a constructive and appropriate manner.

I have read and understand the office policy as stated above

_____ _____

(Patient's Printed Name) (Signature of patient or legal guardian)

_____ _____

Relationship to patient, if other than self Date