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FORMA PACIENTE de ENCUENTRO

Fecha _____ **Chart #** _____ **EHR #** _____

Nombre _____ **Fecha de Nacimiento** _____

idioma preferido_____ **Raza** _____ **Etnicidad** _____

Genero ☐ Hombre ☐ Mujer ☐ Otro _____ **☐ Soltera ☐ Casado ☐ Divorciado ☐ Divuda/o**

Residencia _____

Ciduad _____ **Estatdo** _____ **Codigo Postal** _____

En casa telefono incluyendo codigo de la zona (_____) _____

Numero de telefono celular incluyendo codigo de la zona (_____) _____ **email** _____

El mejor número de teléfono para comunicarse con usted ☐ en Casa ☐ Celular ☐ Trabajo

Nombre de su empleador _____ **Telefono de trabajo** (___) _____

Direcion su empleador _____

Ciudad de su empleador _____ **Estato** _____ **Codigo postal** _____

** **Si el paciente es cadsado escribala informacion acerca del esposo/a, Si el paciente es Menor de edad entonces por favor escribe la siguiente información acerca del guardian**:

Nombre _____ Telefono (___) _____

****

Seguro Primerio- Nombre _____

Dirección de la compañía de seguros _____

Ciudad _____Estado _____ Codigo de la zona _____

Telfono de seguros (_____) _____ Nombre de asegurado _____

Seguro Secundario – Nombre _____ _____

Dirección de la compañía de seguros _____ _____

Ciudad _____ Estado _____ Codigo de la zona _____

Telfono de seguros secundario (_____) _____

La Compensacion de trabajores ☐ Sí ☐ No **Ningún Defecto ☐ Sí ☐ No**

Contacto de emergencia (de otra manera que conyuge) Nombre _____

Relación con el paciente_____ **Teléfono del contacto** (____) _____

Mecionador por (**si el médico – proporcionar nombre completo, dirección, teléfono**): _____

_____

Razón de visita: _____

_____

Nombre _____ **Chart #**_____ **EHR #** _____

¿Cuánto tiempo han existido los síntomas? Duración del tiempo : **día** #_____ semanas #____ meses #_____ años #_____
¿Durante que meses los sitmoas ☐ Estacional ☐ Perenne todo el año
☐ January ☐ February ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

Are your symptoms made worse by? ☐ Cats ☐ Dogs ☐ Other Animals ☐ Barns / Hay ☐ Cosmetics ☐ Dust ☐ Powder ☐ Air Conditioning
☐ Damp Areas ☐ Cold Day ☐ Dry Weather ☐ Hot Day ☐ High Pollution Day ☐ Weather Change ☐ Wet Weather ☐ Wind ☐ Smoke ☐ Perfumes
☐ Powder ☐ Paint Fumes ☐ Soap ☐ House Plants ☐ Mowing Lawns ☐ Insecticides ☐ Newspapers ☐ Wool ☐ Travel / Vacations
Indoors (Explain) _____ **Outdoors (Explain)** _____

Do any of the following cause or make your symptoms worse? ☐ Milk or Milk Products ☐ Fruit or Fruit Juices ☐ Vegetables
☐ Egg or Egg Products ☐ Beer ☐ Wine ☐ Liquors ☐ Wheat Products ☐ Nuts, Beans, Seeds ☐ Cheese ☐ Mushrooms ☐ Chocolate
☐ Vinegar ☐ Fish ☐ Shellfish ☐ Meat ☐ Poultry ☐ Other _____

Have you ever been treated with Allergy Shots? ☐ YES ☐ NO
If Yes, what were you treated for? ☐ Grass Pollens ☐ Weed Pollens ☐ Tree Pollens ☐ Molds ☐ Dust ☐ Cockroach ☐ Mouse/Rat
☐ **Animals ☐ Other** _____

When did you get the Allergy Shots? _____ **Where?** _____
Did the Allergy Shots help you? ☐ Yes ☐ No ☐ Don't Remember

Do You Smoke? ☐ Yes ☐ No If Yes: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Hookah ☐ CBD ☐ Other _____
How Many per Day? _____ How Long did you smoke? _____ Months _____ Years

Drink Alcoholic Beverages? ☐ Yes ☐ No How Often? ☐ Socially ☐ Habitually ☐ Alcoholic History

Drug (non-prescription) Use? ☐ Often/Presently ☐ Sometimes ☐ Never ☐ In the Past

****

Your Medical Condition? ☐ Asthma ☐ Bronchitis ☐ Diabetes ☐ Emphysema ☐ High Blood Pressure ☐ Heart Disease
☐ Hormonal Difficulty ☐ Insect Sting Allergy ☐ Stomach/Digestive Problems ☐ Lactose Intolerance ☐ Gluten Sensitivity ☐ Thyroid Disease
☐ Other Problems _____
List Any Drug/Medication/Latex Allergies: _____
List Any Food Allergies or Sensitivities: _____
List Any Insect/Venom Allergies: _____
Past Medical History: (Indicate Date, Why, Where & What Treatment)
Hospitalizations: _____
ER Visits: _____
Surgery: _____

Medication(s) Used Now (Indicate Name & Dosage): _____
_____

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Family History: ☐ Asthma ☐ Colitis ☐ Eczema ☐ Hay Fever ☐ Migraine ☐ Sinus Problems ☐ Ulcer
☐ **Other illness:** _____

****

Are These Exposures Problematic?

IRRITANTS: ☐ Cleansers ☐ Detergents ☐ Cooking Odors ☐ Perfumes ☐ Powder ☐ Tobacco Smoke ☐ Other Smoke _____
☐ Moth Balls ☐ Motor Fumes ☐ Paint Lacquer ☐ Wax ☐ Glue ☐ Insect Spray ☐ Fertilizers ☐ Ammonia ☐ Room Deodorants
☐ Chemical Fumes ☐ Clorox ☐ _____

TOILETRIES: ☐ Soap ☐ Shampoo ☐ Shaving Cream ☐ After Shave ☐ Spray Deodorant ☐ Hair Spray ☐ Hair Tonic ☐ Hair Dye
☐ Hand Cream ☐ Make-Up ☐ Toothpaste ☐ Denture Cream ☐ Mouthwash ☐ Nail Polish ☐ Other _____

FOODS: ☐ Alcohol ☐ Beer ☐ Cheese ☐ Chocolate ☐ Cold Liquids ☐ Eggs ☐ Fish ☐ Juices ☐ Milk ☐ Nuts ☐ Seasonings ☐ Shellfish
☐ Strawberries ☐ Vegetables ☐ Wheat Products ☐ Wine ☐ Other _____

DRUG ALLERGIES: ☐ Penicillin ☐ Sulfur ☐ Aspirin/NSAIDS ☐ Latex ☐ Anesthesia
☐ Over the Counter (OTC) Drugs – indicate which _____

PETS: Which of these do you have as a pet(s); ☐ Bird ☐ Cat ☐ Dog ☐ Gerbil ☐ Hamster ☐ Horse ☐ Rabbit ☐ Other _____
Is your condition worse around pets? ☐ Yes ☐ No Symptoms _____

INSECT BITES or STINGS: ☐ Large Swelling ☐ Weakness ☐ Sweating ☐ Shortness of Breath ☐ Stuffy Nose ☐ Wheezing ☐ Other _____

WEATHER: ☐ Air Conditioning ☐ Change in Temperature ☐ Cold ☐ Damp ☐ Hot ☐ Humid ☐ Pollution ☐ Smog ☐ Sunlight ☐ Other _____

NEW (Unwashed) CLOTHING: ☐ Coat ☐ Dry-Cleaned Clothes ☐ Shoes ☐ Silk ☐ Starched Clothes ☐ Sweater ☐ Wool ☐ Other: _____

Patient's Name: _____ **Chart #**_____ **EHR #** _____

CONTACTANTS: ☐ Blankets ☐ Cut Flowers ☐ Christmas Trees ☐ Cut Grass ☐ Dust ☐ Feather Pillows ☐ Fiberglass ☐ Furs ☐ Hay ☐ Household Plants ☐ Jewelry ☐ Mattress ☐ Overstuffed Furniture ☐ Plastic ☐ Poison Ivy ☐ Rubber Wool ☐ Rugs ☐ Shoe Polish ☐ Stuffed Pads ☐ Other

GENERAL: ☐ Dizziness ☐ Fatigue ☐ Fainting ☐ Frequent Colds ☐ Nervousness ☐ Sinus Trouble ☐ Other _____

HEADACHE: Where ☐ Back of Head ☐ Front (Face) ☐ Right ☐ Left **WHEN:** ☐ Day ☐ Night ☐ Both Day & Night
Symptoms: ☐ Aching ☐ Throbbing ☐ Sharp ☐ Dull ☐ With Vomiting ☐ With Stuffy Nose
Symptoms: ☐ Better with Sleep ☐ Worse with Tension ☐ Spots before Eyes ☐ Other _____
Symptoms Caused by: ☐ Migraine ☐ Food ☐ Drug/Medication ☐ Sinus ☐ Tension ☐ Other _____

SKIN: ☐ Blisters ☐ Burning ☐ Dandruff ☐ Eczema ☐ Hives ☐ Itching ☐ Perspiration ☐ Rash ☐ Redness ☐ Stinging ☐ Swelling ☐ Athlete's Foot (Where? _____ Is your problem worse after eating? ☐ Yes ☐ No

EYES: ☐ Blurring of Vision ☐ Burning ☐ Dizziness ☐ Glaucoma ☐ Infections ☐ Itching ☐ Pain ☐ Puffiness ☐ Redness ☐ Tearing ☐ Other _____

NOSE: ☐ Bleeding ☐ Broken ☐ Itching ☐ Polyps ☐ Post-Nasal Drip ☐ Sneezing ☐ Snoring ☐ Stuffiness ☐ Trouble Smelling ☐ Previous Surgery ☐ Other _____

TONGUE: ☐ Coated ☐ Itching ☐ Sore ☐ Swollen ☐ Trouble Eating ☐ Other _____

MOUTH: ☐ Adenoids Removed ☐ Bad Breath ☐ Change in Voice ☐ Frequent Throat Clearing ☐ Itching of Roof ☐ Morning Sore Throat ☐ Mouth Breathing ☐ Repeated Tonsillitis ☐ Swollen Lips ☐ Tonsils Removed ☐ Trouble Swallowing

MUCUS: ☐ Bloody ☐ Brown ☐ Clear ☐ Green ☐ Yellow ☐ Thick ☐ Thin **Source of Mucus:** ☐ Lungs ☐ Neck ☐ Throat
Amount per Day: ☐ Teaspoon ☐ Tablespoon ☐ ½ Cup ☐ Other _____

CHEST: ☐ Bronchitis ☐ Cough ☐ Cough when Wheezing ☐ Emphysema ☐ Heart Trouble ☐ High Blood Pressure ☐ Pneumonia ☐ Shortness of Breath ☐ Tightness ☐ Trouble Sleeping ☐ Trouble Walking ☐ Trouble Working ☐ Wheezing ☐ (TB) Tuberculosis ☐ Cancer ☐ Other _____

STOMACH: ☐ Bleeding Gums ☐ Blood in Stool ☐ Cramps ☐ Diarrhea ☐ Gas ☐ Foul Smelling Stool ☐ Gas ☐ Mucus in Stool ☐ Soiling ☐ Vomiting ☐ Other _____ **What Foods make is worse?** _____

JOINTS: ☐ Pain ☐ Stiffness ☐ Swelling ☐ Other _____

MENSES-for Females Only: ☐ Regular ☐ Irregular ☐ Discharge ☐ Itch ☐ Cramps ☐ Infections ☐ Pain ☐ Last Period Date:_____ ☐ **Are You Pregnant?** ☐ Yes ☐ No If Yes, how far along are you _____
Are Your Taking/Using Birth Control? ☐ Yes ☐ No If Yes, what are you using? _____

MENOPAUSE-for Females Only: Menopause Symptoms: ☐ Hot Flashes ☐ Insomnia ☐ Mood Changes ☐ Vaginal Dryness ☐ Other_____

KIDNEY: ☐ Bladder Infection ☐ Chills ☐ Fever ☐ Frequent Urination ☐ Infection ☐ Pain ☐ Recurrent Itching ☐ Other _____

WHERE DO YOU LIVE? ☐ Room ☐ Apartment ☐ Brick House ☐ Wood Frame House ☐ Mobile Home ☐ Basement ☐ Other _____
Age of your Home: ☐ New – Less than 10 years ☐ Medium – 11 to 30 years ☐ Old – Greater than 30 years

LOCATION: ☐ City – 5 boroughs of NYC ☐ Suburbs ☐ Country ☐ Farm ☐ Near Factory ☐ Near Bakery ☐ Seashore ☐ Mountains ☐ Desert ☐ Grain Storage ☐ Swamp ☐ Poultry Yard ☐ Barn ☐ Other _____

PROBLEMS WORSE IN: ☐ Bedroom ☐ Bathroom ☐ Living Room ☐ Kitchen ☐ Attic ☐ Garage ☐ Basement ☐ Indoors ☐ Outdoors ☐ Other _____

PROBLEMS WORSE USING: ☐ Feathers Pills ☐ Comforter

TYPE OF HEATING: ☐ Radiator ☐ Forced Air ☐ Filtered Air ☐ Heat Pump ☐ Electric Heat ☐ Steam Heat ☐ Other _____
TYPE OF COOLING: ☐ None ☐ Window ☐ in Wall ☐ Central ☐ Fan ☐ Other _____

PROBLEMS WORSE WHEN? ☐ At Home ☐ At Work ☐ In Car ☐ In Boat ☐ Exercising ☐ At Beauty Shop ☐ At School ☐ Driving in Traffic ☐ Sweeping ☐ House Cleaning ☐ Making Beds ☐ Around Fan ☐ Around Humidifier ☐ Around Vaporizer ☐ Around Open Windows ☐ Around Heating Ducks ☐ on Windy Days ☐ Taking Hot Baths ☐ Taking Cold Baths ☐ Swimming in Chlorinated Water ☐ In Musty Places ☐ Other _____

PATIENT RESPONSIBILITIES

Audrey Weissman, M.D.
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Please be advised that it is the responsibility of the patient to return to this office to obtain their results regarding any testing done in this office and results of tests ordered at an outside facility by this office.

It is conceivable that in any office an abnormal report may be mistakenly placed in a chart without the doctor having seen the report. It is also possible that a consultant's report may be lost in the mail without the doctor knowing that you had seen the specialist or the results of the consultation. It is also very important for you to return to this office when you are advised of a Follow - up visit, so that there is continuity of your medical care.

It is the patient's responsibility to return to this office, in order to avoid these problems. Patients are strongly advised to return to the office for all follow-ups to ensure that all problems are addressed in a timely and proper manner. You, the patient must also share in the responsibility of maintaining your health care.

We appreciate your cooperation and ask that you sign below indicating your understanding of our office policy.

ASSIGNMENT OF BENEFITS

I authorize the above-named party to release medical information necessary for the processing of my Medical claims.

Signature ____ ***Date*** ______________ ***Print Name:*** _______________________________________

I assign payment of benefits to the above-named party.

Signature ____ ***Date*** ______________ ***Print Name:*** ____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient's Name: ____ **Date of Birth:** ______________

I understand that, under The Health Insurance Portability Accountability Act of 1996, I have certain rights to privacy in regard to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practices.

The practice reserves the right to change the terms of its Notice of Privacy Practices. I understand the Practice will provide current Notice of Privacy Practices on request.

Signature/Relationship: ____ Date: ____________________

Office Use Only *

I was unable to obtain the patients signature.

Employee's Name: ____ Date: __________________

Reason: ____

PHARMACY INFORMATION

Pharmacy Name: ____

Address/City/Zip ____

Phone # (______) ____________________________________ Fax # (______) _____________________________

CANCELLATION POLICY

CO-PAYMENT, CO-INSURANCE, APPOINTMENTS AND CANCELLATION POLICIES

CO-PAYMENT POLICY

All co-payments are due at time of office visit, including all testing co-payments required by your insurance plan. If you have a deductible, that payment is also due in full at time of visit.

APPOINTMENTS AND CANCELLATION POLICY

We strive to provide quality medical care in a timely manner. This not only requires patients making appointments, but also notifying this office in advance if you need to cancel your appointment. This will help us better meet the medical needs of our patients, including someone in need of urgent treatment.

If you do need to cancel your appointment, we require advance notice of 24-hour notice…Tuesday for a Thursday appointment and Saturday morning for a Monday appointment. Remember, appointments are in high demand and notifying us of your cancellation will enable another patient the possibility to be seen by the doctor. **Please call (718) 592-3200 to cancel your appointment.**

LATE CANCELLATIONS ARE CONSIDERED A "NO SHOW"

A "NO SHOW" is a patient who missed their appointment without calling to cancel 1 working day in advance.

A failure to present yourself at the time of your scheduled appointment will be recorded in your chart as a "NO SHOW". This is subject to an administrative fee of $25 per day (a total $75).

I, ____ have read and am aware of the above stated policies.
Print patient's full name

Patient's Signature _____ Date _____ Chart # _____ EHR # _____

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

INTRODUCTION:

Audrey M. Weissman, M.D. understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information" (PHI). "PHI" includes any individually identifiable information that we obtain from you or others that relate to your past or future physical or mental health, the health care you received, or payment for your health care.

As required by law, this notice provides you with the information about your rights and our legal duties and privacy practices with respect to the privacy of "PHI". This notice also discusses the uses and disclosures we will make of your "PHI". We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time, as required by Federal and State Laws including but not limited to the HIPAA Omnibus Rule and to make the revised notice effective for all "PHI" we maintain. Any revised copy of this "PHI" will be available upon request, in our office, and on our website.

PATIENT RIGHTS:

You have a right to obtain a copy of your paper or electronic medical record. You have the right to request a correction to your paper or electronic medical record. We may say "no" to your request, but we'll tell you why in writing within 60 days. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee as allowed by law.
You may request confidential communication and ask us to limit the information we share. You have a right to get a list of those with whom we've shared your information. You have the right to file a complaint if you believe your privacy rights have been violated: U.S. Department of Health and Human Services Office for Civil Rights 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-877-696-6775 or visiting: www.hhs.gov/ocr/privacy/complaints/.

PATIENT'S CHOICES:

You have some choices in the way that we use and share information as we: Tell family and friends about your condition; provide disaster relief; provide mental health care; market our services and sell your information.

_____: You may fax my information to (___) _____
_____: You may leave a voice message on my answering machine or cell phone
_____: You may mail results to my home
_____: Speak to the following family member(s) regarding my medical information

PERMITTED USES AND DISCLOSURES:

We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of these categories of use and disclosure, we have provided a description and an example below. However, not every particular use of disclosure in every category will be listed.

TREATMENT means the provisions, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate to your care.

PAYMENT means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determination of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third-Party Payer about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third-Party Payer for the services rendered to you, we can provide the Third-Party Payer with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release for you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law. If you paid for services-out-of-pocket, we must accommodate any request you provide that we do not disclose your PHI related solely to those services paid for out-of-pocket if the disclosure is to be made to a health plan for payment or health care operations.

HEALTH CARE OPERATONS means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician review, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your "PHI" to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the de-identified information to study health care and health delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your "PHI" in the following ways:

We may share your health information for certain situations such as:
Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety; We can use or share your information for health research; Comply with state or federal laws as required; In response to organ and tissue donations requests: Share health information about you with organ procurement organizations; For worker's compensation claims;
For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services; In response to a court or administrative order, or in response to a subpoena.

I, _____ acknowledge that I have been provided a copy of Audrey M. Weissman, M.D.'s Privacy Notice.
Print Patient's Full Name

Patient's Signature: _____ Date _____

Patient is ☐ unable to or ☐ refuses to sign this acknowledgement. This acknowledgement form will be retained in your record for six (6) years as required by federal law.

Privacy Official: Nancy Packer Phone # (718) 592-3200 e-mail address: rpmahw@gmail.com

_____ _____
Chart # EHR #