Please check and/or fill in the information below and make changes as necessary:

Patient information	**Insurance Information:** ID # _____
Name: _____	Plan Name: _____
Address: _____	Address: _____
_____	_____
Contact Numbers: Home: _____	Insured Party (if not self):
Work: _____ Cell: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
	Relation to Patient: _____

☐ All information above is correct

Please provide the following additional information: **Do you have a secondary insurance: ☐ YES ☐ No**

e-mail address: _____ SS#: _____

Pharmacy Name: _____ Pharmacy Address: _____

Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

HIPPA/Payment Agreement Permission to discuss your health information with others (e.g. spouse, parents, children, significant others):

☐ I do not want my information discussed with anyone other than myself _____ (Please Initial)

☐ I authorize this office to discuss all my health care needs, questions and billing issues with the following authorized representative(s): (please list spouse, parents, children, or those accompanying you to the office)

_____

By signing this form, I consent to the use and disclosure of any and all protected health information about me (or this above indicated under-aged minor) for treatment, payment, or health care operations. This authorization is in effect now and will remain in effective for 2 years from the date of my signature below. I have the right to revoke this consent at any time with a written, dated and signed notification. However, such revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Test Results

I understand that all lab, diagnostic and bone density results will be reviewed in person with a provider. _____

Insurance and Billing Information **Pt intials**

In order to be seen today we must have a copy of your insurance card and driver's license or photo ID. If you do not have your card with you, you may settle your account in full today and our office will provide you with a receipt to file with your insurance. You may also choose to reschedule your appointment for another day. I understand that by signing below I am responsible for payment of any and all fees for services rendered. I am responsible for understanding the terms of my insurance policy including deductibles, co-pays, network providers and all out-of-pocket expenses. I authorize payment to Dr. Kathy Santoriello MD PA and agree that I am responsible for all unpaid balances.

Authorization for Release of Medical Record

I request that Dr. Kathy Santoriello MD PA provide medical care as deemed appropriate to me or this above indicated under-aged minor. I authorize Dr. Kathy Santoriello MD PA to release requested information to my insurance company for the purposes of billing and collection. I further authorize Dr. Kathy Santoriello MD PA and staff access to and or a copy of any and all of my medical records for the purposes of medical treatment and continuity of care from any medical provider or facility. I understand I have the right to a copy of this release.

PATIENT SIGNATURE: _____ DATE: _____

If under 18, Responsible Party: _____ Relationship to Pt: _____ DATE: _____

New Patient Check In Form

Patient Name: Date of Birth: Today's Date:

Reason for Visit: ☐ Routine Annual ☐ Other: _____ Referring Doctor: _____

Please list what you take or use! (Medications/Vitamins/Supplements/Creams/Anything over-the-counter):

Medications (Name and Dose) Vitamins/Over-The-Counter Supplements/Creams

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: ☐ NO ☐ YES (please list) _____

REVIEW OF SYMPTOMS: Please Circle any of the following conditions you have had or now have.

Eye & Vision: loss of hearing; buzzing; infections

Nose & Throat: hoarseness; difficulty swallowing; nosebleed; frequent sneezing; thyroid disorder

Respiratory: shortness of breath; wheezing; cough; asthma; sleep apnea; Tuberculosis

Cardiovascular: chest pain; abnormal heartbeat;
swelling of ankles or feet; varicose veins; heart attack; stroke; leg clots; pacemaker, atrial fibrillation

Gastrointestinal: abnormal pain; nausea or vomiting;
loss of appetite; diarrhea; blood in stool; constipation;
weight loss; heartburn; hepatitis, fatty liver, colitis.

Urinary: urinary incontinence, urinate when coughing, blood in urine, increased frequency; painful urination, wearing pads, nightly urination.

Integumentary: itching skin, rashes, sores not healing, herpes, cold sores, shingles, skin cancers.

Musculoskeletal: joint pain or swelling, difficulty walking, neck or back pain, use of cane/walker/wheelchair.

Neurologic: headaches, dizziness, seizures, numbness or tingling, lapse of memory, blackouts

Blood: diabetes, cholesterol, high blood pressure, clotting disorder, other blood disorder.

Psychological: depression, excessive worry, severe tension, hopelessness, use of medications.

Diet: use of phenphen, use of herbs, eating disorder, swallowing trouble.

Sexual Dissatisfactory: discomfort, pain, lack of sensation, lack of interest, poor arousal.

For MA use only: Vital Signs

HT: _____ WT: _____ BP: _____ Temp: _____ RR: _____ Pulse: ___

LMP: _____ SBE: ☐ YES ☐ NO

OB/GYN History:

How many total pregnancies have you had? _____

How many preterm births (prior to 37 weeks gestation)? _____

How many abortions? _____

How many living children? _____

Around what age did you start your menstrual cycles? _____

☐ Yes	☐ No	Are you currently on birth control? Any complications with taking birth control?(Ex: dizziness, weight gain, nausea)
☐ Yes	☐ No	Have you been vaccinated for the HPV virus?
☐ Yes	☐ No	If not, would you like information on the vaccine?

Medical History: If yes, please state issue, date of diagnosis and treatment.

☐ Yes	☐ No	Do you have a primary care physician? If yes please state name of physician
☐ Yes	☐ No	Have **you** had any history with cancer (Ex: breast, cervical, skin)? Please state type and date of diagnosis?
☐ Yes	☐ No	Have you had any breast issues?(biopsies, abnormal mammograms, fibrocystic breast, breast pain)
☐ Yes	☐ No	Have you had any cosmetic surgery?
☐ Yes	☐ No	Have you had any gynecological issues? (Ex: abnormal pap's, viruses, dryness, libido, procedures)
☐ Yes	☐ No	Have you had any cardiology issues? (Ex: murmur, cholesterol, strokes, pacemaker)
☐ Yes	☐ No	Have you had any pulmonary issues? (Asthma, Sleep apnea, tuberculosis)
☐ Yes	☐ No	Have you had any gastrointestinal issues? (GERD, procedures, constipation, Hepatitis)
☐ Yes	☐ No	Have you had any Urinary issues? (Leaking, prolapsed, procedures, kidney stones)
☐ Yes	☐ No	Have you had any endocrine issues? (Thyroid, metabolism, diabetes, procedures)
☐ Yes	☐ No	Have you had any hematology issues? (Anemia, sickle cell hyper coagulation, procedures)

☐ Yes	☐ No	Have you had any musculoskeletal issues? (Arthritis osteoporosis, knee /back, procedures)
☐ Yes	☐ No	Have you had any neurological issues? (ALS, Parkinson, neuropathy, procedures)
☐ Yes	☐ No	Have you had any psychiatry issues? (Bipolar, anxiety, depression, procedures)
☐ Yes	☐ No	Have you had any rheumatology issues? (Fibromyalgia, RH arthritis, Lupus, procedures)
☐ Yes	☐ No	Have you had any skin issues? (Acne, eczema, psoriasis, procedures)
☐ Yes	☐ No	Have you had any trauma/toxins issues? (Burns, drug overdose, motor vehicle accident, fractures, procedures)
☐ Yes	☐ No	Do you have any other medical history?

Family History:

☐ Yes ☐ No Do you have any family history of breast/ovarian/uterus cancer?
☐ Yes ☐ No Are you adopted or have unknown family history?

Mother: ☐ Living ☐ Deceased
Does she have any major medical diagnosis? (Heart disease, cancer, diabetes, thyroid, breast, Blood pressure, cholesterol)
Father: ☐ Living ☐ Deceased
Does he have any major medical diagnosis? (Heart disease, cancer, diabetes, thyroid, blood pressure, cholesterol)

Social History:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Remarried ☐ Lesbian

☐ Yes	☐ No	Are a tobacco smoker? How many packs a day for how long? ☐ Yes ☐ No Are you ready to quit? ☐ Yes ☐ No If you are ready to quit, may we refer you for smoking cessation?
☐ Yes	☐ No	Do you drink Alcohol? ☐ Yes ☐ No Wine How many drinks do you have a day?

		☐ Yes ☐ No Beer How many drinks do you have a day? ☐ Yes ☐ No Mixed drinks How many drinks do you have a day?
☐ Yes	☐ No	Do you drink caffeine? ☐ Yes ☐ No Coffee How many drinks do you have a day? ☐ Yes ☐ No Tea How many drinks do you have a day? ☐ Yes ☐ No Soda How many drinks do you have a day?
☐ Yes	☐ No	Do you follow any special diet every day? (Ex: Atkins, vegetarian) If so, what kind?
☐ Yes	☐ No	Are you sexually active? ☐ Men ☐ Women ☐ Both How many #(s) of partners had you had in the past? Do you have any history of STD's? If so, state diagnosis.
☐ Yes	☐ No	Do you regularly exercise? ☐ Cardiovascular (Ex: running,bootcamp cycling) How many times per week? ☐ Weight training (Ex: weights, calisthenics) How many times per week?
☐ Yes	☐ No	Do you use any recreational drugs? (Ex: heroin, cocaine, marijuana, pain killers) What drug you use? How often do you use?
☐ Yes	☐ No	Do you have any trouble ☐ falling asleep ☐ staying asleep ☐ hot flashes?
☐ Yes	☐ No	Are you employed? If so, list job title. ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student