RICHMOND INTERNAL MEDICINE GROUP, PC
800 MANOR RD. SUITE 4 STATEN ISLAND, NY 10314
PHONE: (718) 448-6800 FAX: (718) 448-9458

PATIENT REGISTRATION FORM

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City_____ State___Zip_____

Home Phone #_____ Sex: Male or Female

Email: _____ Cell #:_____

Drivers License _____ Referred by:_____

Social Security #_____ Marital Status: Single Married Widow Separated Divorced

Employer: _____ Work #_____

Emergency Contact Name:_____Relationship:_____Phone#_____

Ethnicity: African American __ Caucasian___Asian___Hispanic__Other_____

PRIMARY INSURANCE COMPANY:

Insurance Company:_____Referral Required: Yes____ No____

Policy Holder Name:_____ Relationship:_____

Policy Holder Date of Birth:_____ S/S #:_____

Policy ID #:_____ Group #_____

Copay$_____ Deductible$_____ Co-Insurance$_____

SECONDARY INSURANCE COMPANY:

2nd Insurance Company Name:_____ Referral Required Yes____ No_____

Policy Holder Name:_____ Relationship:_____

Policy Holder Date of Birth:_____ S/S #:_____

Policy ID #:_____ Group #_____

Copay$_____ Deductible$_____ Co-Insurance$_____

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name:
Address:
Date of Birth:
Sex/Gender: ◯ Male ◯ Female
Race: ◯ African American ◯ Asian ◯ Hispanic ◯ White ◯ American Indian
Education Level: ◯ High School Graduate ◯ Some college ◯ College graduate ◯ Graduate school
CHIEF COMPLAINT: (What is your reason for your visit? Briefly state in your own words)

_____

PRESENT ILLNESS:

Please check all that apply:

◯ High blood pressure
◯ Diabetes
◯ Heart disease
◯ Cancer
◯ Ulcers/stomach problems
◯ Circulatory problems
◯ Arthritis
◯ Osteoporosis
◯ Lung problems
◯ Others:

Is there any changes in the severity, character or persistence of your symptoms?: _____
Do you have new symptoms? _____
Are there any aggravating factors of your present illnesses? _____

PAST MEDICAL HISTORY:

Have you had these symptoms?

◯ Cough
◯ Chest pain
◯ Shortness of breath
◯ Joint pain or swelling
◯ Difficulty walking
◯ Pain at night
◯ Bowel/urinary problems
◯ Weight loss/Weight gain
◯ Difficulty sleeping
◯ Loss of balance
◯ Other health complications not listed above: _____

Have you ever been hospitalized? ◯ Yes, Reason: _____ ◯ No
List all surgical procedures done, please include dates:
Type: _____ Date: _____ Type: _____ Date: _____
Type: _____ Date: _____ Type: _____ Date: _____
How would you describe your health status right now?

◯ Excellent
◯ Very Good
◯ Good
◯ Fair
◯ Poor

Please list all medications that are prescribed by your doctor that you are taking, including dosage, duration and indication:

_____

_____

Please list all the over-the-counter medications that you are taking that the doctor should be aware of:

_____

_____

SOCIAL HISTORY:

Marital Status: ◯ Single ◯ Married ◯ Divorced
Do you live with anyone? : ◯ Y ◯ N◯

Do you live in: ◯ Private home ◯ Apartment ◯ Assisted living ◯ Long-term care facility
Occupation: ◯ Full-time ◯ Part-time ◯ Retired ◯ Student ◯ Unemployed
Do you smoke tobacco? A. ◯ Yes 1. *If yes*, how many packs per day? ____ B. ◯ No
Do you drink alcohol? A. ◯ Yes 1. *If yes*, ◯ Everyday ◯ Occasionally ◯ Socially B. ◯ No

FAMILY HISTORY:

Has anyone on the family (parents, grandparents, aunts/uncles, sister/brothers) had:

◯ Allergies
◯ Asthma
◯ High blood pressure
◯ Diabetes
◯ Cancer
◯ Heart disease
◯ Kidney problem
◯ Liver problem

SYSTEMS REVIEW:

General:

◯ Recent weight loss
◯ Recent weight gain
◯ Fever
◯ Fatigue
◯ Night sweats

Skin:

◯ Rashes
◯ Dryness of skin
◯ Lumps
◯ Color changes
◯ Itching
◯ Hair or nail change

Respiratory:

◯ Cough
◯ Coughing up blood
◯ Wheezing
◯ Shortness of breath

Cardiac:

◯ Heart murmur
◯ Swelling of feet
◯ Chest pain
◯ Shortness of breath
◯ Palpitations

Gastrointestinal:

◯ Trouble swallowing
◯ Vomiting
◯ Diarrhea
◯ Jaundice
◯ Heartburn or gas
◯ Rectal bleeding
◯ Abdominal pain
◯ Nausea
◯ Constipation
◯ Hemorrhoids

Urinary:

◯ Frequent urination
◯ Stones
◯ Painful urination
◯ Blood in urine
◯ Difficulty urinating
◯ Difficulty holding urination

Musculoskeletal:

◯ Joint stiffness
◯ Backache
◯ Gout
◯ Arthritis
◯ Muscle pains
◯ Muscle cramps

Neurological:

◯ Fainting
◯ Weakness
◯ Tingling of hands
◯ Blackouts
◯ Numbness
◯ Change in memory
◯ Seizures
◯ Tremors

Patient Signature: _____ ***Date:*** _____

Richmond Internal Medicine Group, P.C

HIPPA (Health Insurance Portability and Privacy Act) Acknowledgement

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I have been provided with the Notice of Privacy Practice for the office of **Richmond Internal Medicine Group P.C.** (Drs. Chacon, Perrone, Hanna) and understand my privacy rights as stated within.

Patient Print Name: _____

Patient Signature: _____

IF YOU ARE A MINOR, OR A PATIENT WHO COORDINATES HIS/HER CARE WITH A FAMILY MEMBER OR OTHER THIRD PARTY, PLEASE SEE AND SIGN BELOW:

I, _____ hereby authorize the person(s) listed below, access to my protected health information by phone, in person or in writing.

1. _____ _____ _____
(Name) **(Relationship)** **(Telephone Number)**

2. _____ _____ _____
(Name) **(Relationship)** **(Telephone Number)**

3. _____ _____ _____
(Name) **(Relationship)** **(Telephone Number)**

Please understand that we will not be able to release any information about your medical condition to anyone not authorized by you. It is your responsibility to change/update this information as necessary.

Patient Signature: _____ Date: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

PRIVACY PRACTICES

Acknowledgement of Receipt of Notice of Privacy Practices

In accordance with New federal laws (HIPPA, Health Information Portability and Accountability Act) regarding privacy of medical file, we must ask that you read and sign acknowledgement that we provided you with our privacy practices. I have received a copy of the notice of Privacy Practices for Richmond Internal Medicine Group and acknowledge the same by signing below.

Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Richmond Internal Medicine Group for the purpose of diagnosis or treatment of me by Richmond Internal Medicine Group treating doctor may be conditioned upon my consent, as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Richmond Internal Medicine Group is not required to agree to the restrictions that I may request. However, if Richmond Internal Medicine Group agrees to a restriction that I request, the restriction is binding on Richmond Internal Medicine Group and Richmond's treating doctor.

I have the right to revoke this consent, in writing, at any time, except to the extent that RIMG treating doctor or RIMG has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health provider, a health plan, my employer or a health care clearing house. This protected health information relates my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Richmond Internal Medicine Group Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of RIMG. The notice of Privacy Practices also describes my rights and the Richmond Internal Medicine Group duties with respect to my protected health information.

Richmond Internal Medicine Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Authorization Form

I authorize my physician and/or administrative and clinical staff to use my protected health information for the purpose of evaluating health, diagnosing medical conditions, providing treatment, and securing payment for the same. This authorization shall be in force in perpetuity or as long as any open balances remain in effect.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact, Ricardo Baez, at 800 Manor Road, Suite 4, Staten Island, NY 10314. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party.

_____ Date: _____

Signature of Patient or Personal Representative

_____ _____

Print Name of Patient or Personal Representative

Relationship to Patient