Robert Mormando, DO, FACP
Specializing in Internal Medicine

Michael Rodriguez, MD, FAAP
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410 Hallock Avenue
Port Jefferson Station, New York 11776
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REGISTRATION FORM

(Please verify the information we have. Make any changes or additions needed. Please print.)

Today's Date:	PCP:

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (Circle One)
					Single / Mar / Part/ Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex
❑ Yes	❑ No					

Street Address	City	State	ZIP Code	Social Security	Home Phone No.

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No.

E-mail address:

❑ Check here if you would like to communicate with office via E-mail

Person Responsible for Bill	Birth Date	Address (if different)	
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No.

Is this patient covered by insurance?	❑ Yes ❑ No				
Please indicate primary insurance	❑ Medicare	❑ Empire Plan	❑ Empire BC/BS	❑ United Healthcare	❑ CIGNA
❑ Oxford	❑ Vytra	❑ GHI	❑ Aetna	❑ Other	

Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Policy #	Co-Payment

Patient's Relationship to Subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize or insurance company to release any information required to process my claims.

x

PATIENT/GUARDIAN SIGNATURE　　　　DATE

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)*	Male/Female	**DOB** / /

Marital Status: Single Partnered Married Separated Divorced Widowed

Previous or Referring Doctor: **Date of Last Physical Exam:**

PERSONAL HEALTH HISTORY

Childhood Illness: Measles Mumps Rubella Chicken Pox Rheumatic Fever Polio

Immunizations and Dates:		
	Tetanus	Pneumonia
	Hepatitis	Chicken Pox
	Influenza	MMR *Measles, Mumps, Rubella*

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

Continued on Next Page

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:		
Name of Drug	Strength	Frequency Taken

Allergies to Medications:	
Name of Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise: Sedentary (No exercise) Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)
Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet: Are you dieting? Yes No If yes, are you on a physician prescribed medical diet? Yes No
# of meals you eat in an average day?______________

Caffeine: None Coffee Tea Cola # of Cups/Cans Per Day?

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:

Do you drink alcohol?	Yes	No
If yes, what kind?______________________ How many drinks per week? _____		
Are you concerned about the amount you drink?	Yes	No
Have you considered stopping?	Yes	No
Have you ever experienced blackouts?	Yes	No
Are you prone to “binge” drinking?	Yes	No
Do you drive after drinking?	Yes	No

Tobacco:

Do you use tobacco?	Yes	No
Circle one: Cigs Pipe Cigars Chew Amt:________ How long? yrs. Quit:		

Drugs:

Do you currently use recreational or street drugs?	Yes	No
Have you ever given yourself street drugs with a needle?	Yes	No

Continued on Next Page

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Sex:

Are you sexually active? Yes No

If yes, are you trying for a pregnancy Yes No

If not trying for a pregnancy, list contraceptive or barrier method used ______

Any discomfort with intercourse? Yes No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of these illnesses? Yes No

Personal Safety:

Do you live alone? Yes No

Do you have frequent falls? Yes No

Do you have vision or hearing loss? Yes No

Do you have an Advance Directive and/or Living Will? Yes No

Would you like information on the preparation of these? Yes No

Physical and/or mental abuses have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? Yes No

Please remember that the following recommendations are very important to maintaining your health.

When in a car, wear your safety belt at all times. While riding a motorcycle or bicycle, wear a helmet. Always have functional smoke detectors and fire extinguishers in your home. If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm. Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

		Age Now	At Death	Health Problems or Cause of Death
Father				
Mother				
Siblings	**M F**			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			

		Age Now	At Death	Health Problems or Cause of Death
Children	**M F**			
	M F			
	M F			
	M F			
Grandparents (Mother's Side)z				
	Male			
	Female			
Grandparents (Father's Side)				
	Male			
	Female			

MENTAL HEALTH		
Is stress a major problem for you?	Yes	No
Do you feel depressed or cry frequently?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Have you ever attempted suicide or thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY		
Age at onset of menstruation: Date of last menstruation:		
Period every days. Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	Yes	No
Have you had a D&C, hysterectomy, or Cesarean section?	Yes	No
Any urinary tract, bladder, or kidney infections within the last year?	Yes	No
Any blood in your urine?	Yes	No
Any problems with control of urination?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Do you have menstrual tension, pain, irritability, or other symptoms at or around time of period?	Yes	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes	No
Date of last pap smear ___/___ mammogram ___/___ , rectal exam ___/___, and colonoscopy ___/___.		

MEN ONLY		
Do you usually get up to urinate during the night? Yes No If yes, # of times		
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No
Date of last prostate exam ___/___, rectal exam ___/___, and colonoscopy ___/___.		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Skin	Back	Energy Level
Head/Neck	Intestines	Ability to Sleep
Ears	Bladder	**Other Pain/Discomfort:**
Nose	Bowels	
Throat	Circulation	
Lungs	**Recent Changes In:**	
Chest/Heart	Weight	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____

please sign

SIGNATURE ALSO REQUIRED ON LAST PAGE!!!

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Name:

Social Security Number:

Address:

City, State, ZIP CODE

Phone Number:

Patient 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 IT CAREFULLY.

Purpose of This Notice: Port Jeff Medical Care, PC (THE PRACTICE) is required by law to maintain the privacy of your confidential medical record and to provide you with a notice of our legal duties and privacy practices with respect to your information. This Notice describes your legal rights, advises you of our privacy practices, and lets you know how they permitted to use and disclose this information.

Uses and Disclosures of PHI: THE PRACTICE may use your patient information for the purposes of treatment, payment, and other health care operations. The law permits them to use your confidential information for these areas without your consent. Examples are as follows:

Treatment: This includes verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including physicians who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of information via radio or telephone to the hospital as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

Payment: This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your information and submitting bills to insurance companies (either directly or via third party billing), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

Health Care Operations: This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care, obtaining financial and legal services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Reminders for Scheduled Transports or Information on Other Services: We may contact you with a reminder about scheduled appointments for non emergency ambulance service, or for other information about other services we provide or other health related benefits or services that may be of interest to you.

Use and Disclosure of Information Without Your Consent: THE PRACTICE is authorized to use your medical record without your consent, authorization, or written permission in certain situations, including:

- **Emergencies:** if your medical condition is such that time is of the essence and attempting to obtain consent would present an obstruction to timely care, or if your condition is such that you are unable to effectively and competently give consent. In these situations we will attempt to get your written consent after the emergency.
- To a relative, friend or individual involved in your care
- To public health authorities in certain situations (reporting a birth, death, or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect, to report domestic violence, to report product defects, or to notify someone about exposure to infectious disease as required by law).
- For health oversight activities, such as audits, government investigations
- Response to judicial and legal proceedings, such as response to subpoena or other legal process, after reasonable attempts to notify you of the subpoena.
- For law enforcement activity in limited circumstances, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime
- For military, national defense and security
- To avert a serious threat to a person or the public at large
- For worker's compensation proceedings as required by law
- Any other use of your confidential patient record will require your signed consent in advance.

Patient Rights

As a patient, you have a number of rights:

The right to access, copy or to inspect your medical record: This means you may come to our offices during regular business hours and copy most of the information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may charge a reasonable fee for you to make such copies. We may deny you access to your information in some circumstances. Certain types of denials may be appealed. We have forms available to request access to your information, and will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical record, you should contact the privacy officer listed at the end of this notice.

The right to amend your medical record: You may ask us to amend written medical information we have about you. This would generally occur within 60 days of your request and will notify you when this occurs. We are permitted under the law to deny your request under certain circumstances, like when we believe the information you are asking us to amend is correct. This denial can be appealed. If you wish to amend the medical information we have about you, contact the privacy officer at the end of this notice.

The right to request an accounting of our use and disclosures of your medical record: You may request an accounting of our use and disclosure of your medical information we have made in the last six years prior to the date of your request. We are not required to provide uses and disclosures of your PHI for purposes of treatment, payment or health care operations, or uses and disclosures made prior to April 14, 2003 . If you wish an accounting of your medical record, contact the privacy officer listed at the end of this notice.

The right to request restrictions on uses and disclosures of your medical record: You have the right to request restrictions on how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. However, if you request a restriction, and that information is needed to provide you with emergency care, then we may use the information or disclose the information to a health care provider to provide you with emergency treatment. THE PRACTICE is not required to agree to any restrictions you request, but any restrictions agreed to by THE PRACTICE is binding on it.

Legal Rights and Complaints: Notice of any changes in this privacy policy may be shown directly on the consent form and this Notice will be updated when any significant changes occur. THE PRACTICE reserves the right to change the terms of this notice at any time, and the changes will be effective immediately. We also reserve the right to make any changes effective for medical records that we have created or received prior to the effective date of the Notice provision that was changed.

You also have the right to complain to us or the Secretary of the Federal Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or the government. Should you have any questions, comments or complaints you may direct all inquiries to the privacy officer, Ms. Laura Mormando, Port Jeff Medical Care, P.C., 410 Hallock Avenue, Port Jefferson Station, NY 11776.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Patient Signature: ______________________________ Date: ______________________________

AUTHORIZATION TO BILL YOUR INSURANCE

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf to Port Jeff Medical Care, for service furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature ______________________________ Date:______________________________

Port Jeff Medical Care, P.C.
The Harbor of Good Health
410 Hallock Avenue
Port Jefferson Sta. NY 11776

PREVIOUS PHYSCIAN'S ADDRESS:

____

____

____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: ____________________ **Date of Birth:** __________________
Previous Name: ____________________ **Social Security #:** __________________

I request and authorize ____ to release health care information of the patient named above to:

Port Jeff Medical Care, P.C.
410 Hallock Avenue
Port Jefferson Station, ***NY*** ***11776***

___ This request and authorization applies to:
___ Health care information relating to the following treatment, condition, or dates:
____
___ All health care information
___ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________________ Date Signed: ____________________

<u>THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.</u>