Patient Registration Form

Please Print *Date*_____

Name:_____ Sex ___F ____M SS#_____
Address:_____City_____Zip_____
Mailing Address (if different than above)_____
Phone_____ Cell Phone_____ Age_____ DOB _____
Marital Status: Single_____ Married____ Divorced/Separated_____ Widow/Widower_____
Patients Employer_____ Occupation_____
Employers Address_____ Work Phone_____
Emergency Contact_____ Phone _____
Spouse/Significant Others Name_____ Mother's Maiden Name_____
Spouse/Significant Others DOB:_____ SS#_____
Spouse's/Significant Others Employer _____ Occupation_____
Employers Address _____Work Phone_____
Pharmacy Name & Address_____ Pharmacy Phone #_____
Ethnicity Non-Hispanic/Spanish Origin ____ Spanish/Hispanic Origin_____ Patient Declined/Unknown_____
Language Preference_____ Race_____
Email _____

HIPAA DOCUMENTATION
(Please answer all questions below and then sign and date)

1 I acknowledge that I have been given the opportunity to read and/or receive a copy of _____. YES NO

2.

Leave appointment message on:	**YES**	**NO**
Home Phone (including autocall)?		
Mobile Phone (including autocall)?		
Mobile Text (including autocall)?		
Work Phone?		
With another person? List name(s) below		
Send via Mail?		
Send via Email/Portal?		

Leave Medical information on:	**YES**	**NO**
Home Phone (including autocall)?		
Mobile Phone (including autocall)?		
Mobile Text (including autocall)?		
Work Phone?		
With another person? List name(s) below		
Send via Mail?		
Send via Email/Portal?		

3. Person(s) authorized to discuss the above information & relationship

_____ _____

_____ _____

Signature_____ Date_____

*** I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Signature_____ Date_____

*** I authorize the payment of medical benefits to above stated physician or supplier for services rendered.

Signature_____ Date_____

FamilyCare
Medical Group, PC

Theresa Lipsky, MD
Nicole Pastore, PA-C

4652 NIXON PARK DR.
SYRACUSE, NEW YORK 13215

NO SHOW FEE AND LATE CANCELLATION FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurences.

Due to high patient demand, and limited availability of appointments, we have instituted a fee up to $50.00 for no show and a $30.00 fee for late cancellations. As of January 1st 2009, you must give 24 hours advance notice to cancel/reschedule appointments.

By singing below, I acknowledge that I have read and understand this policy.

_____ _____

Patient Signature Date

_____

Patient Name (printed)

_____ _____

Witness Signature Date

NEW PATIENT DATA SHEET

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Birthplace: _____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Are you a smoker? ☐Y ☐N ☐ past? If yes, how many per day? _____ How many years? _____
Do you drink Alcohol? ☐Never ☐Rarely ☐Daily ☐Socially Only Is it a problem? ☐Y ☐N

List Any Allergies:

_____

List the medications you are currently taking:

Name of Medication	Dosage	How Many Times Per Day

Please list other healthcare providers & their specialty you see regularly:

_____

List any previous hospitalizations, excluding normal pregnancies:

Operation, illness or procedure	Year	Doctor	Hospital

Personal Health History

Check off any conditions that you have, or have had in the past, if any:

☐Stroke	☐Rheumatic Fever	☐Jaundice	☐Blood Transfusions
☐Seizures	☐High Blood Pressure	☐Gall Bladder Disease	☐Chicken Pox
☐Broken Bones	☐Heart Murmur	☐Liver Disease	☐Depression
☐Cataracts	☐Heart Attack	☐Ulcers	☐Thyroid Problems
☐Glaucoma	☐Enlarged Heart	☐Diverticulitis	☐Diabetes
☐Asthma	☐High Cholesterol	☐Kidney Stones	☐Migraines
☐Pneumonia	☐Breast Lump	☐Urinary Infection	☐Cancer
☐Emphysema	☐Prostate Problems	☐Anemia	☐Skin Cancer
☐Arthritis	☐Blood Disorder		

To the best of your knowledge have you ever been exposed to:

☐Sexually Transmitted Diseases ☐Tuberculosis ☐Hepatitis B ☐HIV

Family Health History

(Please check the conditions that are in your family)

	Mother	Father	Sister	Brother	Grandmother	Grandfather	other
Healthy							
Heart disease							
Diabetes							
High blood pressure							
COVID							
High cholesterol							
Stroke							
Colon cancer							
Breast cancer							
Prostate cancer							
Osteoporosis							
Other							

For Women Only:

Total number of pregnancies: _____ Number of births: _____

Are you Currently Pregnant: ☐Yes ☐No Due Date:_____

Age of first period/menstruation: _____

Age of last period/menstruation (menopause/hysterectomy): _____

Do you have concerns about your periods or menopause you'd like to discuss? ☐No ☐Yes

If you are having periods, how often do they occur? Every _____ days. How long do they last? _____ days

Do you have the following medical forms on file?
If not would you like information? ☐yes

☐ Advance Directive for Health Care (ADHC)

☐ Health Care Proxy

☐ Durable Power of Attorney (DPA) for healthcare decisions)

☐ Living Will

☐ MOLST (Medical Orders for Life Sustaining Therapy)

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 _____ (Initials) I authorize _____ (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.**