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BRIGHTON MEDICAL ASSOCIATES
FCMG

PLEASE READ CAREFULLY

THIS PACKET MUST BE COMPLETELY FILLED OUT OR IT WILL NOT BE CONSIDERED.

Some insurance companies **do not** cover physical examinations. It is the patient's responsibility to confirm the coverage of physical exams with their insurance carries, prior to the time of service, to avoid any out-of-pocket charges.

If your insurance does not cover your physical in full, or partially, you are responsible for the payment of the remaining balance, if any.

Your signature below indicates that you understand the above statements and that you will be held accountable for the remaining balance for any physical exams performed at Bright Medical Associates.

Print Name: _____ D.O.B: _____

Signature: _____ Date: _____

THIS PACKET MUST BE COMPLETELY FILLED OUT OR IT WILL NOT BE CONSIDERED!

182 Intrepid Lane • Syracuse, NY 13205
315-218-7020 • Fax 315-218-7058

NOTICE

NO-SHOW POLICY

Beginning January 1, 2017, we will be charging a $25.00 fee for office visits, $50.00 fee for surgical clearances, hospital follow ups, new patient appointments, GYN/PAP and physical appointments to patients who fail to keep with scheduled appointments. To avoid this fee patients, need to cancel their appointments 24 in advance. The fee is NOT covered by insurance and will be the patient's responsibility.

COPAY

Copays and outstanding balances are due at the time of your appointment. If you do not have your copay/balance, you may be asked to reschedule your appointment.

INSURANCE CARDS

Please have your insurance cards with you at every appointment. A current copy of your insurance card is required. Please attach copy here:

Print Name: _____ DOB: _____

Signature: _____ DOB: _____

Family Care Medical Group P.C.
Brighton Medical Associates
182 Intrepid Lane, Syracuse NY 13205
Phone: (315) 218-7020 Fax: (315) 218-7058

Patient:_____ Date of Birth: _____

Doctor To Release Medical Records:
Name: _____
Address:_____
City: _____
Phone:_____
Fax: _____

Doctor To Receive Medical Records:
Name: _____
Address:_____
City: _____
Phone:_____
Fax: _____

Reason for Records Request: ☐Transfer of Care ☐ Continuation of Care ☐ Moving out of Area

*****Please check **ONE** of the following boxes*****

☐ Medical Records, **INCLUDING** information related to the treatment of substance abuse or dependency, psychiatric or mental health treatment, and information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

☐Entire Medical Records, **EXCLUDING** information related to the treatment of substance abuse or dependency, psychiatric or mental health treatment, and information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

☐Records of care from _____ to _____ **INCLUDING** information related to the treatment of substance abuse or dependency, psychiatric or mental health treatment and information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

☐Records of care from _____ to _____ **EXCLUDING** information related to the treatment of substance abuse or dependency, psychiatric or mental health treatment and information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

If deemed necessary by Dr._____, I authorize this information to be sent via fax transmission. This applies to all information in my medical records protected under the regulations in 42 Code of the Federal Regulations, Part 2.

I authorize medical information to be released as indicated above. I understand this release is effective until _____ but that I may revoke my consent at any time by providing written consent to the above-named party.

_____ _____
Patient Signature (or Patient Legal Guardian) Date

_____ _____
Witness Date

Brighton Medical Associates

182 Intrepid Lane
Syracuse, NY 13205
(315) 218-7020

Patient Registration Form

Please Print

Name: _____ DOB: _____ Sex: ☐ Female ☐ Male
SSN: _____ Phone: _____ Cell: _____
Address: _____ City: _____ Zip: _____
Mailing Address (if different than above)_____
Email: _____ Preferred Language: _____
Race: _____ Ethnicity: ☐ non-Hispanic ☐ Hispanic ☐ Decline/Unknown
Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widow/Widower
Emergency Contact: _____ Emergency Contact # _____
Patient Employer: _____ Occupation: _____
Employer Address: _____ Work Phone: _____
Pharmacy Name: _____ Pharmacy Number: _____
Pharmacy Address: _____

Insurance Information

Primary Insurance: _____ ID#_____
Subscriber Name: _____ Relationship to insured: _____
Subscriber DOB: _____ Subscriber SSN: _____ Subscriber Phone: _____

Secondary Insurance: _____ ID#_____
Subscriber Name: _____ Relationship to insured: _____
Subscriber DOB: _____ Subscriber SSN: _____ Subscriber Phone: _____

HIPAA

Person(s) authorized to discuss appointment/medical information with: (Name & Relationship)

_____ _____
_____ _____
_____ _____

Signature: _____ Date: _____

***I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operation 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 the above stated physician or supplier for services rendered.

Signature: _____ Date: _____

Health History Questionnaire

Date:_____

The Health History Questionnaire is an important part of your medical record. It should be filled out as completely as possible by you personally since you are the individual to be examined. All information will be strictly confidential. Please print or write clearly. We expect it will take you 20-30 minutes to complete this questionnaire.

Personal Background & Information:

Name: _____ DOB: _____ Sex: ☐ Female ☐ Male
Are you currently under the care of a physician: ☐No ☐Yes, who?: _____
Date of last physical: _____ Where were you born?: _____
How long have you lived in this area?:_____ How many people live with you in your home?_____
Who lives with you in your home? ☐ Spouse ☐Child(ren)- Ages:_____ ☐Other: Specify_____
How many times have you moved in the last 5 years?: _____ Do you have any pets?: ☐Yes ☐ No

Please check health hazards you have been exposed to because of your job, hobbies, or sports:
☐Dust or Fumes ☐Extreme ☐Noise ☐Heat ☐Cold ☐Heights ☐ Heavy Machinery ☐Chemicals
☐Asbestos ☐Radiation ☐Other:_____
Please explain the checked items above:_____
Do you have any personal restrictions about any type of medical treatment, such as blood transfusions?
☐No ☐ Yes, If yes please explain: _____

Present Health:

How would you rate your health now? ☐Excellent ☐Good ☐Fair ☐Poor
Please list any current medications prescribed by a physician (i.e.: tablets, capsules, liquid, injections)

_____

_____

Please list any over the counter medications you use on a regular basis (vitamins, aspirin, antacids, etc.)

_____

_____

Please list any medications to which you are allergic to (Penicillin, Sulfa, other)

_____

_____

Is there any known allergy to insect stings? (bee, yellow-jacket, etc.) Yes No
Do you have false teeth? ☐Yes ☐No Do you wear glasses or contacts?☐ No ☐Yes, specify: _____

Health History:

Please check if ***YOU*** have or have ever had any of the following:

☐Radiation or Xray	☐Tuberculosis	☐Seizures or Epilepsy	☐Diabetes
☐Treatment	☐Bronchitis	☐Polio	☐Syphilis
☐Abnormal Chest or	☐Asthma	☐Blood Transfusions	☐Gonorrhea
other Xray	☐Chronic Lung	☐Hepatitis	☐Herpes
☐Heart Murmur	Disease	☐Liver Disease	☐VD
☐Rheumatic Fever	☐Pneumonia	☐Mono	☐Infertility
☐High Blood Pressure	☐Allergies	☐Unexplained Fevers	☐Cancer (specify)
Stroke	☐Blood, Albumin,	☐Arthritis	
☐Heart Disease	Sugar in Urine	☐Gout	
☐Heart Attack	☐Kidney Stones	☐Thyroid Trouble	

Please list any hospitalizations or operations, including one-day surgical procedures (exclude normal deliveries)

Date:	Type of injury/illness/surgery	Name of hospital	Location of hospital

Please list any other healthcare providers you see:

_____

_____

_____

Immunizations:

Please indicate the year of the most recent immunization:

_____Flu _____Shingles _____ Pneumonia _____TDAP

_____MMR _____Polio

For Men ONLY:

Last PSA: _____ Last Colonoscopy:_____ Have you had a vasectomy? ☐Yes ☐No

*Men please go to family health history

For Women ONLY:

Last Mammogram:_____ Last Bone Density:_____ Last Colonoscopy:_____

What was your age at first menstrual period:_____ When was your last Pap Smear?: _____

Have you had an abnormal pap smear? ☐Yes ☐No Do you practice self-breast exams? ☐Yes ☐No

Date of last menstrual cycle: _____ How would you describe your flow: ☐Light ☐Moderate ☐Heavy

Please indicate the number of the following:

_____Pregnancies ____Cesarean Sections _____Miscarriages _____Living Children _____Abortions

_____Normal Deliveries _____Premature Deliveries

During pregnancy did you ever have:

☐Serious weight problem ☐Serious Illness ☐ High Blood Pressure ☐Edema or Swelling

☐Kidney Infection ☐ Protein in Urine ☐ Diabetes

Family Health History:

Please indicate the present health of your close relatives:

	AGE	Present health or if deceased, cause of death	Age at death
Mother			
Father			
Brother			
Sister			
Child			

If any blood relatives have any of the following, please circle the condition and indicate the specific relations before each problem.

(M) Mother (F) Father (B) Brother (S) Sister (G) Grandparents (C) Children

_____Heart Disease	_____Breast Cancer	_____Depression
_____Stroke	_____Uterus Cancer	_____Suicide Attempt
_____High Blood Pressure	_____Colon Cancer	_____Nervous Breakdown
_____High Cholesterol	_____Cancer (Other)	_____Gout
_____Sudden Death	_____Crippling Arthritis	_____Thyroid Problems
_____Bleeding Disorder	_____Lupus	_____Seizures/Fits
_____Sickle Cell Disease	_____Glaucoma	_____Epilepsy
_____Leukemia	_____Diabetes	_____Kidney Disease
_____Lung Cancer	_____Alcoholism	
_____Cervix Cancer	_____Nervous Disorder	

Health Habits:

1. Do you smoke: ☐ Yes ☐ No, If no please go to question 2

How long have you smoked?:_____ Do you inhale?: ☐ Yes ☐ No Last low dose CT scan:_____

Please check appropriate boxes:

☐ Cigarettes- Packs per day? _____ ☐ Cigars- How many per day? _____

☐ Pipe - How often? _____ ☐ Chewing Tobacco – How often? _____

2. Did you smoke in the past? ☐ Yes ☐ No, If no please go to question 3

When did you stop smoking? _____ How long did you smoke? _____ Do you inhale?: ☐ Yes ☐ No

Please check appropriate boxes:

☐ Cigarettes- Packs per day? _____ ☐ Cigars- How many per day? _____

☐ Pipe - How often? _____ ☐ Chewing Tobacco – How often? _____

3. Do you drink Alcohol: ☐ Yes ☐ No Approximately how many days a week do you drink? _____

How many years have you been drinking? _____ When was your last drink? _____

What do you drink? (Beer, wine, shots, etc.) _____

Have you ever tried to cut back on your drinking? ☐ Yes ☐ No

Have you ever been annoyed at criticism of your drinking? ☐ Yes ☐ No

Do you feel guilty about drinking? ☐ Yes ☐ No

Do you sometimes drink in the morning when you get up? ☐ Yes ☐ No

Have you ever been told by your doctor to stop or cut down on your drinking? ☐ Yes ☐ No

4. Do you drink caffeine? ☐ Yes ☐ No How many cups? _____
5. Do you have reason to suspect that you have been exposed to the AIDS virus? ☐ Yes ☐ No
6. Do you exercise regularly? ☐ Yes ☐ No If yes: What do you do, for how long, how many times per week?_____

Request for Information:

Please circle those items you would like to discuss with a health professional or receive info about:

Family	Stress	Anxiety
Drug use	Depression	Parenting
Venereal diseases	Alcohol use	Smoking
Birth control	Infertility	Herpes
Premenstrual syndrome	AIDS	Other: (Specify)_____
Sex	Diet	

Other Concerns, Questions, Comments

_____

_____