Forest Hills Medical Services, PC

PATIENT REGISTRATION INFORMATION FORM (PLEASE PRINT)

Name:			I prefer to be called:	
Date of birth:	Sex:	SSN:	Marital Status:	
Address:		City:	State:	Zip Code:
Cell#		Home#	Work#	

The best time to contact you: A.M ☐ P.M ☐ on my: Cell phone ☐ Home phone ☐

Email Address:

Race: Ethnicity: (Please check) ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Do not wish to provide

Referring Provider:	Address:	Phone:
Primary Care Provider:	Address:	Phone:

Emergency Contact Name:	Relationship:		Sex:
Address:	Home#	Work#	Cell#

How did you find us?	Do you have a Health Savings or Flex Account?

EMPLOYMENT INFORMATION

Employer:	Employment Status: F/T P/T or Unemployed		
Employer address:	City:	State:	Zip Code:

PRIMARY INSURANCE INFORMATION

Ins Name:		
Subscriber ID#		Group#
Subscriber Name:	Date of Birth:	SSN:

SECONDARY INSURANCE INFORMATION

Patient Relationship to Subscriber: (Please check) ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other

Subscriber ID#		Group#
Subscriber Name:	Date of Birth:	SSN:

PATIENT PORTION WAIVER APPLICATION
(i.e. deductibles, co-insurance, etc…)

You may use this form if you believe you have experienced financial hardship and feel you may qualify for a waiver of your copayment and/or deductible. You may seek a waiver only for financial hardship and this document is considered an attestation of such. You also acknowledge that there are no guarantees, neither explicit nor implicit, that Forest Hills Medical Services, PC will grant such a waiver.

Signature of Patient__________________________Printed Name______________________Date_______________

----------FOR OFFICIAL USE ONLY - Please do not mark or write anything below this line------------

☐ Approved – Comments ____

☐ Not Approved – Comments ____

FOREST HILLS MEDICAL SERVICES OB/GYN HISTORY FORM

Please take the time to fill out the entire form

Name: ____ Date of Service ______________________
(First) (Last)

Date of Birth: ________/________/________

Reason for Visit: ____

Pharmacy: ________________ Address: ____
(street) (city) (zip)

Pharmacy Phone #: ____________________________________

Medication

Please list any medications you are currently taking including birth control, creams, aspirin, vitamins, and hormones:

Name of Medication	Strength	How often you take it
______________________	__________________	__________________
______________________	__________________	__________________
______________________	__________________	__________________
______________________	__________________	__________________

Medication Allergies

Please list any medications you are allergic to

Medication	Your Reaction
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

Are you allergic to Latex? Yes No

Medical Conditions

Please list all medical conditions that you have, such as diabetes, high blood pressure, thyroid disease, asthma, history of cancer, etc…

____

____

Please list any history of STD's in you or your sexual partner, such as syphilis, sores, gonorrhea, herpes, warts, trichomonas, etc:

____

____

Diagnostic/ Health Maintenance

Date of your last Pap smear: ___________________
Location where you had your last Pap smear: ____________________________________
Were the results normal? Yes No

Date of your last mammogram: ___________________
Location where you had your mammogram done: ______________________________________

Date of your last Dexa (bone density scan): ___________________
Location where you had your last Dexa done: ____

Have you ever had a colonoscopy? Yes No
If yes, what year? _______________
Location where you had the colonoscopy done: ____

Menstrual History

Do you still have a menstrual cycle? Yes No

If no, what is the reason? ____

When was the first day of your last menstrual cycle? ____________________________

Age when you first began your menstrual cycle? __________________

Number of days from the first day of one cycle to the first day of next cycle: __________________

How many days of flow? __________________

Cramping: None Mild Moderate Severe

What type of birth control do you use? ____

Are you sexually active? Yes No Never

Menopausal History

Are you experiencing menopausal symptoms? Yes No

Age of onset of menopause: _______

Are you currently on hormone replacement therapy? Yes No

Obstetrical History

No. of Pregnancies _______ No. of living children _______ No. of vaginal deliveries _______

No. of full term births ______ No. of miscarriages _______ No. of Cesarean sections _______

No. of premature births ______ No. of abortions _______

Family History (please circle one)

Mother:	Living	Deceased	Father:	Living	Deceased
Brother:	Living	Deceased	Sister:	Living	Deceased
Brother:	Living	Deceased	Sister:	Living	Deceased

Please list any known illnesses, medical conditions, and cause of death:

Mother: ____

____

Father: ____

____

Brother(s): ____

____

Sister(s): ____

____

Is there a family history of any of the following: (please circle all that apply)

Breast cancer   Ovarian cancer   Uterine cancer   Colon cancer

If yes, please specify which family member and their age when diagnosed:

Family Member	Type of Cancer	Age when Diagnosed
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Social History

Do you exercise?   Yes   No   What type of exercise? ____________________________________

How many times a week? ____________

Occupation/Place of Employment: ____

Relationship Status: ____________________________   Partner's Name: ____

Partner's Occupation: ____

Do you use illicit/street drugs? (Please circle one)   Yes   No

Do you drink alcohol?   Yes   No   Type: _________________________   How often: __________

Do you currently smoke?   Yes   No

Have you smoked in the past?   Yes   No

If yes, when did you quit? ________________________________

Surgical History

Please list any surgeries you have had including C-sections, tonsillectomy, gallbladder, oral, etc…

Surgery	Date
____	__________________
____	__________________
____	__________________
____	__________________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Social Security Number

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 applicable law, I understand that:

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 below. In the event the health information described below includes any of these types of information, and I initial the line on the box below, I specifically authorize release of such information to the person(s) indicated below.

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.

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.

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.

Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.

A **COPY** of this Authorization shall have the same force and effect as original.

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

Forest Hills Medical Services, PC - 108-16 63rd Road, Forest Hills, NY 11375

Tel: (718) 897-5331 Fax: (877) 389-3138

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

Specific information to be released:

- ▫ Medical Record from (insert date) ____________________ to (insert date) ____________________
- ▫ Abstract: (all tests, labs, EKGs, echocardiograms, procedure reports, discharge summary etc…
- ▫ Entire Record

▫ Other: ______________________________

____

____

____

Include: (Indicate by Initialing)

________ **Alcohol/Drug Treatment**

________ **Mental Health Information**

________ **HIV-Related Information**

Reason for release of information: ▫ At request of individual ▫ Other:	Date or event on which this authorization will expire:
If not the patient, name of person signing form:	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.

____ Signature of patient or representative authorized by law.	Date: ______________________________

* **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.**

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