Patient Registration

Label

Last name:_______________ First name:___________________ Age:_________ Date of Birth: ____________________

Address: __________________________________ Apt#_______ City:_________________State:_______Zip Code:_________

County: ___________________________ Email: ___________________________________

Do you want our office to contact you within 24 hours ❍ NO ❍ YES Telephone number to be contacted. _________________

Work Tel #:___________________ Cell Tel #:____________________

Social Security Number:________-______-_______ Employer:___________________________________

Notify in Case of Emergency:_______________________ Relationship:__________________________________

Telephone of Emergency Contact:___________________ Does this person know the reason for your visit?___________

Demographic information

State or country of Birth:_______________________ ❍ NO ❍ YES Married Ethnicity/Race:___________

Circle highest grade completed (Circle one): 6 7 8 9 10 11 12 13 14 15 16 17 18 ❍ NO ❍ YES Current Student

Referral / insurance information

Name of insured:

Payor/insurance Company:______________________ Relationship to insured:_____________________

insurance ID # :________________________________ Medicaid ID # : ___________________________

Referred By:_______________________ Personal Doctor:________________ Dr. tel # :____________

prior to admission, i acknowledge that I was directed to the Parkmed website for information on advanced directives / healthcare proxy, patient rights and disclosure of ownership. if i did not access the website, I acknowledge that this information was provided to me when I arrived at the office.

PLEASE CHOOSE YOUR METHOD OF PAYMENT CAREFULLY:

If you choose to pay cash check here:_________

I understand that payment in full is due at the time services are rendered. I understand I will be receiving a bill for lab services from Quest Diagnostics Laboratory or LabCorp by mail.

If you are using Medicaid today check here:__________

I certify that the Medicaid card that I am using to cover my services is mine. I have no other medical coverage. I understand that if Medicaid does not cover the services i am about to receive, I will need to pay for these services myself.

If you are using your commercial insurance today check here:_________

I hereby authorize my insurance company to send payment directly to Parkmed NYC, Mid-Manhattan Physician Services, P.C., Quest Diagnostics Laboratory, LabCorp and/or Omnicare Anesthesia for the services provided during this visit. I further authorize such providers to furnish my medical records to my insurance company for the purposes of review, investigation, or evaluation for this claim. Furthermore, I authorize sharing of my medical records by and between Parkmed NYC, LLC and Mid-Manhattan Physician Services, P.C.

Reimbursement rates will vary considerably among commercial insurance carriers. Please be aware that patients who can pay us cash at the time of their procedure receive a discount from our “customary and standard charges” that we bill your insurance company. This discount will not be made available to your insurance company. I understand that if the insurance company does not cover the services I am about to receive, I will need to pay for these services myself.

Patient Signature:_______________________________________ DATE:________________

PARKMED NYC **PATIENT HISTORY**

Name____ **Age**__________
FIRST LAST

Medical History

In order for Parkmed NYC to provide you with the best medical care, it is necessary to have your complete medical history. Please fill out this questionnaire as accurately as possible. THIS INFORMATION WILL REMAIN CONFIDENTIAL.

❍ NO ❍ YES ALLERGIES? ❍ NOVOCAINE ❍ PENICILLIN ❍ TETRACYCLINE ❍ IODINE ❍ SULFA DRUGS ❍ SEAFOOD ❍ LATEX ❍ OTHER ____________________

❍ NO ❍ YES HOSPITALIZED? If yes, give date & reason, include childbirth____________________

❍ NO ❍ YES SURGERY before? What kind and when? ____________________

❍ NO ❍ YES SEDATION before? If Yes - ❍ Local ❍ Sedation ❍ Both

❍ NO ❍ YES PROBLEMS WITH ANESTHESIA? Explain ____________________

❍ NO ❍ YES BODY PIERCING? Where____________________

❍ NO ❍ YES SMOKE? Number of packs a day? ______ How long? ____________________

❍ NO ❍ YES LOOSE TEETH? ❍ NO ❍ YES DENTURES? ❍ NO ❍ YES CONTACT LENSES? Height ______ Weight______

Do you have any of the following?

NO	YES	
❍	❍	anemia
❍	❍	asthma, hay fever
❍	❍	bleeding (excessive)
❍	❍	blood clot in veins
❍	❍	breast feeding now
❍	❍	breast lump, tumor
❍	❍	cancer
❍	❍	chest pain (severe)
❍	❍	chlamydia
❍	❍	diabetes
❍	❍	dizzy or fainting spells-recurrent
❍	❍	drug addiction
❍	❍	epilepsy, convulsions, seizures
❍	❍	fibroid, tumor
❍	❍	gonorrhea (V.D.)
❍	❍	headaches: frequent and severe
❍	❍	heart disease, heart murmur
❍	❍	hepatitis, liver disease
❍	❍	herpes
❍	❍	high blood pressure
❍	❍	had infection of uterus, ovaries (PID)
❍	❍	kidney disease
❍	❍	ovarian cysts
❍	❍	pneumonia
❍	❍	psychiatric care w/medical treatment
❍	❍	pulmonary embolus
❍	❍	had rheumatic fever
❍	❍	sickle cell anemia/trait
❍	❍	stomach ulcer
❍	❍	had stroke
❍	❍	syphilis (V.D.)
❍	❍	thyroid problems
❍	❍	trichomonas
❍	❍	tuberculosis
❍	❍	Other (PLEASE SPECIFY) __________

DO YOU TAKE ANY OF THE FOLLOWING ?

NO YES Medication/Drugs ________________

NO YES Herbs/Over The Counter Meds ____________

First Day of Last Menstrual Period ________

	How many	Dates of last
Total Pregnancies (including today)	_____	_____
Total Live Births	_____	_____
Total Still Births	_____	_____
Total C-sections	_____	_____
Total Tubal Pregnancies	_____	_____
Total Miscarriages	_____	_____
Total Previous Abortions	_____	_____

Previous problems with deliveries or abortions?__________

List of Medications Currently Taking

Medication	Dosage

I acknowledge that I have been provided with a copy of this facility's privacy notice.

Patient's Signature ______________________________ **Date** ______