NYU Langone
MEDICAL CENTER

Faculty Group Practice Patient Demographic Form

Patient Information

Name (Last, First, MI)	Today's Date

Street Address	City	State	Zip

Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

SSN	Date of Birth	Gender ☐ Male ☐Female	Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated □ Partner □ Other

Race	Ethnicity	Preferred Language	Email address

Financially Responsible Party

Is patient responsible party/guarantor? ☐Yes☐No(If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)

Name	Address	City/State/Zip	Relationship to Patient

Occupation	Employer	Email Address	Date of Birth

Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

Emergency Contact

Name	Relationship to Patient

Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

Referral Info

Referring Physician's Name	Physician Phone/Fax (if known) ( )
Physician Address	

PCP Info

Primary Care Physician's Name (Check if same as Referring Physician above☐)	Physician Phone/Fax (if known) ( )
Physician Address	

Insurance Information

Primary Insurance Company	Policy #	Group #

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ______________	Name of Subscriber (if other than patient)

Subscriber's Social Security #	Gender ☐ Male ☐Female	Date of Birth	Employer of Subscriber	Work Phone ( )

Secondary Insurance Company	Policy #	Group #

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ______________	Name of Subscriber (if other than patient)

Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone ( )

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: ____ Date: ______/______/______

Guarantor Signature (if other than patient):______________________________ Date: ______/______/______

FACULTY GROUP PRACTICE FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

1. **RELEASE OF INFORMATION:** I authorize NYU School of Medicine, my treating physicians and their respective designees, to use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes. _____**Initials**

2. **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to NYU School of Medicine. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. ______ **Initials**

3. **FINANCIAL LIABILITY:** I have been provided a copy of the NYU School of Medicine financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to NYU School of Medicine for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

   - My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at NYU School of Medicine and I have not obtained such an authorization or referral or I receive services in excess of such authorization or referral, and/or
   - My health plan determines that the services I receive at NYU School of Medicine are not medically necessary and/or not covered by my Insurance plan, and/or
   - My health plan coverage has lapsed or expired at the time I receive services at NYU School of Medicine, and/or
   - I have chosen not to use my health plan coverage. ______ **Initials**

4. **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

   Patient's Medicare Number _________________ **Patient Signature** ___________________________

5. **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at NYU School of Medicine; such as, anesthesia, interpretation of cardiac tests, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payor. ______ **Initials**

6. **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that I may incur a cancelation fee if I do not provide 24 hour notice of cancelation, or if I do not keep my appointment and have not canceled. _______ **Initials**

I have been provided the Faculty Group Practice Patient Financial Polices. I understand the information listed above which has been fully explained to me.

________________________________ ________________

Patient Signature **Date**

________________________________ ________________

Guarantor Signature **Date**

NYU Faculty Group Practice
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). In this notice I was advised of how health information about me may be used and disclosed by NYU Faculty Group Practice physicians and staff. I was also told how I may obtain a copy of this information and correct errors in my health information.

____

Print Name of Patient

____

Signature of Patient (or Financially Responsible Party)

____

Relationship to Patient

____

Date

NYU Langone Medical Center Electronic Health Information System

I have received the NYU Langone Medical Center Electronic Health Information System Fact Sheet. It describes (1) the purpose of the NYU Langone Medical Center Electronic Health Information System; (2) how it works; and (3) how the providers participating in the NYU Langone Medical Center Electronic Health Information System will record and access my health information.

I understand that by signing this form, NYULMC providers directly involved in my care may access my health information, including my electronic prescription records, and that it will be available to my other health care providers in the system, as described in the Fact Sheet.

I acknowledge receipt of the Electronic Health Information System Fact Sheet and consent for all of my providers who participate in the NYU Langone Medical Center Electronic Health Information System to create and/or access and use my electronic health record (EHR) in order to provide my medical care. I understand that this consent will remain in effect unless revoked in writing.

____ ________________

Signature of patient or representative authorized by law Date

If not the patient, name (print) of person signing this form:	Authority to sign this form on behalf of the patient (example: parent. legal guardian or health care proxy):

10/08/2009

PERSONAL HISTORY FORM

NYU Cardiology Associates
530 1st Avenue, Suite 9U, New York, NY 10016
212-263-7751

Date

Name:	Age:	DOB:	Sex:	SSN:
Weight—Now:	One year ago:	Maximum:	When:	

PAST MEDICAL HISTORY

Please √ any that you have ever had.

- □ Heart attack
- □ Heart Failure
- □ High Cholesterol
- □ Hypertension
- □ Heart Murmur
- □ Coronary Artery Disease
- □ Problems with circulation
- □ Testing (check all that apply)
  - □ Abnormal EKG
  - □ Echocardiogram
    When? Where? Normal?
  - □ Stress test
    When? Where? Normal?
  - □ Angiogram
    When? Where?
  - □ Angioplasty or stent
    When? What hosp?
- □ Rheumatic Fever
- □ Congenital Heart Disease
- □ Diabetes
- □ Cancer—Type?
- □ Asthma, Emphysema (COPD)
- □ Pneumonia
- □ Anemia
- □ Osteoporosis
- □ Rheumatoid arthritis
- □ Osteoarthritis
- □ Lupus
- □ Thyroid Disease
- □ Gout
- □ Gallbladder Disease
- □ Liver Disease or Hepatitis
- □ Colitis—Type?
- □ Hemorrhoids
- □ Peptic Ulcers
- □ Esophagitis or Gastritis
- □ Hiatus Hernia
- □ Meningitis
- □ Urinary Tract Infection
- □ Gonorrhea, Syphilis, Herpes, Chlamydia
- □ AIDS
- □ Tuberculosis
- □ Head injuries
- □ Epilepsy
- □ Migraine Headaches
- □ Mental Illness
- □ Hay Fever
- □ Hives or Eczema
- □ Skin Disorders
- □ Broken bones

SURGICAL HISTORY

What surgery have you had?

Have you ever received a blood transfusion?

□ No □ Yes Date:

(WOMEN ONLY)

Date of last menstrual period
Last PAP Smear/Pelvic Exam
Number of live births
Miscarriages
C-Sections
Complications of Pregnancy
Date of last mammogram
Age of onset of menopause

(MEN ONLY)

Enlarged prostate? □ No □ Yes

MEDICATIONS
(PRESCRIPTION, SUPPLEMENTS, AND OVER THE COUNTER)

Name	Dose	Frequency

MEDICATION ALLERGIES
(Describe Reaction)

FAMILY HISTORY

	Living or Deceased?	Health Issues
Father:		
Mother:		
Siblings:		

Who in the family has had:

- □ Heart trouble?
- □ Stroke?
- □ High blood pressure?
- □ Diabetes?
- □ Cancer of any type?

SOCIAL HISTORY

Do you smoke? □ No □ Yes
If no, did you ever smoke? □ No □ Yes
How long?
How much?
When did you quit?
How much alcohol do you consume per week?
What kind?
Have you used recreational drugs? No Yes
IV Drugs? □ No □ Yes
Have you ever been treated for alcoholism or drug habit? □ No □ Yes
Marital status:
How many children do you have?
Occupation

SYSTEM REVIEW

NYU Cardiology Associates
530 1st Avenue, Suite 9U, New York, NY 10016
212-263-7751

Please √ any that you now have or have had in the past 6 months.

▫ Headache
▫ Night sweats
▫ Fatigue
▫ General weakness
▫ Appetite:
▫ Good
▫ Fair
▫ Poor
▫ Blurred vision or double vision
▫ Eye irritation or discharge
▫ Eye pain
▫ Discomfort looking at light
▫ Change in vision
▫ Do you wear eyeglasses/contact lenses? No / Yes
▫ Date of last exam?
▫ Earaches or discharge from ears
▫ Ringing in ears or decreased hearing
▫ Nosebleeds
▫ Nasal congestion
▫ Sinusitis
▫ Hay Fever
▫ Strange, persistent odors or tastes (circle if yes)
▫ Loss of taste
▫ Hoarse voice
▫ Sore throat
▫ Sores in mouth
▫ Soreness or bleeding of gums on brushing
▫ Trouble swallowing
▫ Growth in neck or throat
▫ Chest pain
▫ Angina
▫ Pain in arm(s)
▫ Change in color of fingers
▫ Palpitations or fluttering of heart
▫ Swelling of hands, feet or ankles AM PM
▫ Leg cramps:
▫ On walking
▫ At night
▫ Shortness of breath:
▫ Wakes you up
▫ On walking several blocks
▫ On walking one flight of stairs
▫ On lying down
▫ Coughing up blood
▫ Chronic or frequent cough:
▫ Dry
▫ With phlegm
▫ Wheezing

▫ Heartburn, indigestion, belching
▫ Nausea or vomiting
▫ Avoidance of any foods
▫ Abdominal pain or cramps
▫ Diarrhea
▫ Constipation
▫ Blood in stool
▫ Difficulty or pain with urination
▫ Do you get up at night to urinate?
▫ How many times?
▫ Blood in urine
▫ Lose urine on coughing or sneezing
▫ Too frequent urination
▫ Vaginal or penile discharge
▫ Genital sores
▫ Problems with sex
▫ Backaches
▫ Joint pain or swelling
▫ Stiffness
▫ Dryness of skin
▫ Change in hair texture or skin texture
▫ Any skin rash
▫ New or change in moles or skin lesions
▫ Dizziness
▫ Tingling or weakness of hands or feet
▫ Loss or change in sensation of hands or feet
▫ Trembling of arms, hands or legs
▫ Seizures
▫ Fainting? When?
▫ Depression
▫ Anxiety
▫ Inability to stand heat / cold (circle if yes)
▫ Excessive appetite
▫ Excessive thirst
▫ Enlarged glands
▫ Easy bruising
▫ Other bleeding
▫ Hot flashes

List any other conditions for which you are treated and/or have been diagnosed:

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Patient Signature____________________ Date________

Reviewed by____________________ Date________