Sandra Costley MD
500 New Hempstead Rd. Ste F
New City, NY 10956
(845) 639-3123

PATIENT REGISTRATION FORM

Please print all information

Patient Name : *Last* : *First* : *MI* :

Date of Birth: Sex (M) (F)

Address: Street & Number:

City: State: Zip:

Home Phone: Work Phone:

Employer:

Employer Address:

City: State: Zip:

Relationship to Guarantor: Spouse child c) other(specify)

GUARANTOR INFORMATION: Please complete if person responsible for bill is other than above

Last : *First* : *MI* :

Address: Street & Number:

City: State: Zip:

Date of Birth:

Home Phone: Work Phone:

INSURANCE INFORMATION:

Primary Insurance Company:

Policy No. Group No.

Secondary Insurance Co. Policy No.

TO MY INSURANCE CARRIERS:

1. I authorize the release of any medical information necessary to process my insurance claims(s).
2. I authorize and request payment of medical benefits directly to my physicians
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this form may be used in lieu of the original.
5. I agree to pay all charges not covered by my insurance carrier(s). These changes include but are not limited to deductibles and copayments on my insurance policy.

Patient (or Representative) Signature: _____ Date: _____

Typing your name above qualifies as your signature

History Questionnaire Name: Date:

Medical Problems: Allergies:

Medications:

Previous Hospitalizations and Surgeries:

Review of Systems:

General	Yes	No
fevers		
chills		
poor appetite		
fatigue		
malaise		
weight loss		
weight gain		

Heart	Y	N
chest pain		
palpitations		
fainting		
shortness of breath w or w/o activity		
shortness of breath when laying flat		

GYN	Y	N
Vag discharge		
Vag sores		
Irreg periods		
Heavy periods		
Pain during relations		
contraception		

Psychiatric	Y	N
depression		
anxiety		
memory loss		
phobias		
suicidal thoughts		
hallucinations		
paranoia		

Eyes	Y	N
blurred vision		
double vision		
irritation		
discharge		
vision loss		
eye pain		

Urinary	Y	N
infections		
weak stream		
frequency		
burning		
blood in urine		
blood in semen		
leaking urine		
erectile dysfunction		

Muscular	Y	N
back pain		
joint pain		
joint swelling		
muscle cramps		
muscle weakness, stiffness		
bone fractures		

Endocrine	Y	N
cold intolerance		
heat intolerance		
excessive thirst, increase sweating		

ENT	Y	N
ear pain		
discharge		
ringing		
hearing loss		
stuffy nose		
nose bleeds		
sore throat		
hoarseness		
diff. swallowing		

GI	Y	N
vomiting		
diarrhea		
constipation		
change in bowel habits		
abdominal pain		
bloody stools		
pain w/ movement		

Neuro	Y	N
weakness		
numbness		
tingling		
seizures		
fainting		
tremors		
dizziness		

LUNGS	Y	N
cough		
shortness of breath		
excessive sputum		
coughing up blood		
wheezing		

Hematology	Y	N
easy bruising		
bleeding problems		
enlarged lymph nodes		

Skin	Y	N
rashes		
lesions		

Allergy/Immune	Y	N
HIV exposure		
urticaria		
hay fever		
Persistitant infections		

Social history:

Do you smoke Y N

For how many years:

How many per day:

Drink alcohol? Y N

Use illegal drug? Y N

What type of work do you do?

Family Illnesses? Who:

For Females only::

1^{st} day last period:

Menstrual flow:

Reg/Irreg/Pain/Cramps

days flow: _____

days cycle: _____

pregnancies: _____

miscarriage: _____

abortions: _____

Age of menopause: _____

Immunizations::

Tetams:	Y	N
Flue:	Y	N
Pneumovax:	Y	N
Hepatitis B:	Y	N
Shingles:	Y	N

Immunizations::

Colonoscopy (m/yr): _____

Mammogram (m/yr): _____

PAP (m/yr): _____

Patient's signature :

Typing your name above qualifies as your signature

Doctor's Signature :

Typing your name above qualifies as your signature