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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

Healthix

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow my healthcare providers and payers to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from the different places where I get healthcare can be accessed using a statewide computer network. I can fill out this form once and allow All Healthix Participants who provide me with treatment or care management services to electronically access my information; OR I can have my consent choice apply only to the S and K Medical Associates, in which case I may be presented with this form again by a different Healthix Participant. Healthix is a not-for-profit organization that securely shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA and New York State Law. To learn more, visit Healthix's website www.healthix.org.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

I want my consent decision to apply to:
ALL Healthix Participants
S and K Medical Associates

ONE Box is checked below to the left of my choice

☐ 1. I GIVE CONSENT to access my electronic health information through Healthix to provide healthcare services.

☐ 2. I DENY CONSENT to access my electronic health information through Healthix unless it is to provide me health care services IN A MEDICAL EMERGENCY ONLY.
Note: This pertains only to Healthix organizations that provide emergency care, such as hospital emergency rooms. Emergency access does not pertain to S and K Medical Associates since they do not provide emergency care.

☐ 3. I DENY CONSENT to access my electronic health information through Healthix for any purpose, even in a medical emergency.

Name _____ **Date** _____

Details about the information accessed through Healthix and the consent process:

1. How Your Information May Be Used. Your electronic health information will be used only for the following healthcare services:
   * Treatment Services. To provide you with medical treatment and related services.
   * Insurance Eligibility Verification. To check whether you have health insurance and what it covers.

* Care Management Activities: These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple healthcare services provided to you or supporting you in following a plan of medical care.
* Quality Improvement Activities. To evaluate and improve the quality of medical care provided to you and all patients.

2. What Types of Information about You Are Included. If you give consent, ALL of your electronic health information will be available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

* Alcohol or drug use problems & diagnoses
* Birth control & abortion (family planning)
* Genetic (inherited) diseases or tests
* HIV/AIDS
* Mental health conditions
* Sexually transmitted diseases
* Medication & dosages
* Diagnostic information
* Allergies
* Substance use history summaries
* Clinical notes
* Employment information
* Living situation
* Social supports
* Claims encounter data
* Lab test
* Trauma history summary
* Discharge summary

3. Where Health Information about You Comes From. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749, Ext. 1.

4. Who May Access Information about You, If You Give Consent. Only doctors and other staff members of the organization(s) who carry out activities permitted by this form as described above in paragraph one may access your medical information. If you indicated your consent decision applies to All Healthix Participants, that means all Participants as of the date this form was signed.

5. Public Health and Organ Procurement Organization Access. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Healthix at 877-695-4749, Ext. 1; visit Healthix's website: www.healthix.org ; call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. Re-disclosure of Information. Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed if accompanied by the required statements regarding prohibition of re-disclosure.

8. Effective Period. This consent form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity, your consent choices will remain effective with the newly merged entity.

9. Changing Your Consent Choice. You can change your consent choice at any time and for any provider organization or health plan by submitting a new consent form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision, they are not required to return your information or remove it from their records.

10. Copy of Form. On you grant consent, you will be able to print a copy of this consent form.

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Consent For Participation in NYSIIS for Individuals 19 Years of Age or Older

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

I give my consent for S&K Medical Associates **(name of doctor or organization) to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.**

The immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

Print Name

Date of Birth

Signature

Typing your name above suffices as a signature

Date

S&K Medical Associates Questionnaire

Male: ◯ Female: ◯

Please add dates for the following:

Complete Physical Examination:

Mammogram(F)

Bone Mineral Density (F)

Colonoscopy

Pap smear (F)

Opthalmology

Immunizations:

Tetanus

Pneuomovax(>65)

Flu

Prevnar 13 (>65)

Shingles

Typing your name below qualifies as your signature

Patient Signature