Peter Kelt, M.D.

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Notice of Privacy Practices
Patient Acknowledgement of Receipt of Notice

This is to acknowledge that I have received and reviewed the Peter Kelt, M.D. Notice of Privacy Practices. Should I have any questions regarding the Notice of Privacy Practices, I understand that I can contact the Practice at (631) 749-3149

Patient Name (print): _____

Patient's Signature: _____

Date: _____

I authorize any holder of medical or other information about me to release to the Social Security Administration And Health Care Financing Administration or its intermediaries, carriers or private insurance, any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

We strongly urge you to review your own medical policy. You must familiarize yourself with both the benefits and non-covered services of your insurance contract. Since our practice deals with many insurance carriers, we cannot guarantee that all services provided to you will be covered by your carrier. Any services we provide, even under assignment, which are rejected or not covered may be billed to you. Again, please review the contract you signed with your medical carrier.

Co-pays are due at the time of my visit. If I do not make the co-payment on the day of my visit, I will be charged an additional $10.00 for each month that I am sent a bill.

I have read the above statement and agree to be responsible for payment of services rendered to me.

SIGNATURE_____ DATE_____

GENERAL MEDICAL INFORMATION

Describe current medical problem/reason for today's visit:_____

Present medications:_____

Allergies to medication:_____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent:_____

Other physicians currently treating you:_____

Previous or other medical problems:_____

List any previous surgeries or hospitalizations (include number of miscarriages and live births):_____

_____

Females only: are you pregnant, planning a pregnancy or nursing a child: ____yes ____no

Do you smoke: ___ yes ___ no __Cigarettes __Pipe __ Cigars # of years: ___ How much?____
Interested in stopping? _____

Do you regularly drink alcohol? ____ yes ____ no How many ounces/beers per day?_____

Do you drink coffee? ____ yes _____ no How many cups per day:_____

Are you under a lot of pressure at home or work: _____yes _____no
Please describe: _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following?:
(check all that apply)

__Chest pain/Presure/Tightening
__ Hypertension
__ Heart attack
__ Stroke
__ Headaches
__ Glaucoma
__ Allergies or Eczema
__ Depression
__ Blood in stool
__ Asthma
__ Dizzy spells
__Cancer
__Diabetes
__Arthritis
__Difficult hearing
__ Glaucoma
__ Memory loss
__ Hemorrhoids
__Kidney disease
__Shortness of Breath
__TB/Lung disorder
__Ulcers
__Skin disorders
__Hepatitis
__Cataracts
__Digestive problem
__Frequent urinary infections

IMMUNIZATIONS:

(Year last received if known)

Small pox _____
Tetanus_____
Typhoid_____
Polio_____
Influenza:_____
Pneumonia:_____
Rubella:_____
Hepatitis: _____

FAMILY HISTORY

	Father	Mother	Father's parent s	Mother's parents	Siblings	Children
High blood pressure	—	—	—	—	—	—
Epilepsy	—	—	—	—	—	—
Cancer	—	—	—	—	—	—
Eczema/Psoriasis	—	—	—	—	—	—
Heart attack/Stroke	—	—	—	—	—	—
Diabetes	—	—	—	—	—	—
Asthma	—	—	—	—	—	—
Hay fever	—	—	—	—	—	—