WMCHealth **Physicians**
Advanced ENT Services

Please print clearly

Patient Age: _____ **If Patient is a minor please indicate:**

Mother's Name:_____ **Father's Name:_____**

Mother's Occupation:_____ **Father's Occupation: _____**

Patient Name: _____

Address: _____ Apt/Unit#: _____

City:_____State: _____Zip Code: _____

Home #:_____ Work#: _____ Cell#:_____

Patient DOB:_____ Patient Sex: _____

SS#: _____ Patient Marital Status: ___Single __Married __Other

Language: (please circle one) Chinese English French German Italian Japanese Portuguese Russian Spanish

Race: (please circle one) American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander Other Race White

Ethnicity:(please circle one) Hispanic or Latino Not Hispanic or Latino Unknown

Email Address:_____

Emergency Contact:_____ Phone #:_____

Employer Name: _____

Address: _____

Primary Dr: _____ **Referring Dr: _____**

Address:_____ **Address:_____**

Phone #:_____ **Phone #:_____**

Fax#:_____ **Fax#:_____**

Pharmacy Name_____Phone:_____

Address_____

Prescription Coverage_____ ID#_____ Phone# :_____

*****Patient Signature:_____ Date:_____**

WMCHealth **Physicians**
Advanced ENT Services

Please print clearly

Please check appropriate box and sign below:

☐ There has been NO change in my insurance since my last visit.

☐ There has been a change in my insurance. Please update information.

Name:_____ DOB:_____

Insurance Information:

Primary Ins:_____ Policy #:_____ Group #:_____

Address:_____

Phone # :_____

Policy Holder Name:_____

Policy Holder DOB_____ Policy Holder SS#:_____

Policy Holder Relation to Patient: _____

Secondary Ins:_____ Policy #:_____ Group #:_____

Address:_____

Phone # :_____

Policy Holder Name:_____ Relation to Patient: _____

Policy Holder DOB: _____ Policy Holder SS#:_____

*****Patient Signature:_____ Date:_____**

Patient Name _____ Date of Birth: _____ (mm/dd/yyyy)

WMCHealth **Physicians**
Advanced ENT Services

Health History Questionnaire- New Adult Patient

Please fill this form out as completely as possible and bring this to your appointment.

Date of Appointment: _____(mmlddlyyyy)

Referring MD: _____

Primary MD: _____

Preferred Pharmacy (Name, Street, City): _____

What is the reason for your visit (chief complaint)? _____

Past Medical History (Circle any medical problems you have had) ▢ Check here if no past medical problems.

Cardiovascular	Coronary Artery Disease; Congestive Heart Failure; Elevated Cholesterol; High Blood Pressure; Heart Attack; Arrhythmia (palpitations)
Eye/Ear/Nose/Throat	Cataracts; Glaucoma; Chronic Ear Infections; Hearing Loss; Tinnitus; Vertigo; Nasal Polyps; Sinus Problems; Recurrent Tonsillitis
Gastrointestinal	Hepatitis; Liver Disease; Cirrhosis; Hernia (hiatal); GERD (gastroesophageal reflux)
Pulmonary	Asthma; COPD; Tuberculosis; Sleep Apnea
Genitourinary	Enlarged Prostate; Hernia (inguinal); Kidney Stones; Acute Renal Failure; Chronic Renal Failure
Hematologic	Bleeding/Clotting Disorder; Anemia; Deep Venous Thrombosis
Infectious Disease	HIV/AIDS; Mononucleosis; STD (Type _____); Bronchitis; Pneumonia
Metabolic/Endocrine	Diabetes Mellitus (Type _____); Hyperthyroid (high thyroid); Hypothyroid (low thyroid)
Neurologic	Migraine; Dementia (Type _____); ALS; MS; Stroke; Seizures; Neuropathy
Psychiatric	Anxiety; Depression; Substance Abuse
Rheumatologic	Rheumatoid Arthritis; Autoimmune Disease (Type _____)
Cancer	Type(s): _____
Other (specify)	

Past Surgical History (Check any surgeries you have had and indicate date of surgery if known) ▢ Check here if no past surgeries.

▢ Tonsillectomy
▢ Adenoidectomy
▢ Facial Cosmetic Surgery (Type _____)
▢ Facial Fracture Surgery (Type _____)
▢ Ear Surgery (Type _____)
▢ Sinus Surgery
▢ Heart Surgery
▢ CABG (Heart Bypass)
▢ Heart Valve Replacement
▢ Cholecystectomy (Gall bladder removal)
▢ Hysterectomy
▢ Joint Replacement
▢ Hernia Repair
▢ Brain Surgery
▢ Appendectomy

Other: _____

Patient Name _____ Date of Birth: _____ (mm/dd/yyyy)

Medication List

Please list the names of any medications that you are currently taking below. Please indicate the correct dosage and frequency (if known). Include supplements, herbals and over the counter medications. If you are unsure, ask your clinician.

Medication Name	Dose/Frequency (how often taken)

Allergies / Adverse Reactions

▢ No known medication allergies.
▢ No known food allergies.
▢ No known environmental allergies.

Please indicate any medications, foods, etc. to which you have had an allergic or bad reaction. Please include the reaction to the food or medication, if known (e.g. hives, difficulty breathing, rash, etc.)

_____

_____

_____

Have you ever had any problems or reactions to anesthesia? ▢ No ▢ No prior anesthesia ▢ Yes (please explain below)

_____

Social History

What is your most recent occupation (if age 18 years or older)? _____

Do you, or have you ever, smoked?
▢ Never Smoked
▢ Former Smoker
▢ Current Smoker
▢ Exposed to Second Hand Smoke (Current or Past?)

If you currently smoke or formerly smoked:
Age started smoking: _____
Age quit smoking: _____
Packs per Day: _____
Other smokeless tobacco products used: _____

Do you drink alcohol?
▢ Never
▢ Rarely
▢ Occasionally (socially)
▢ Daily
▢ Former alcohol intake; none for _____ years

Do you, or have you ever, used recreational drugs?
▢ Never
▢ Former user (Quit _____)
▢ Current user (Please indicate type and amount below)
_____
_____

Do you consume caffeine: ▢ No ▢ Yes (Type and amount:_____)

What is your daily water intake? _____

Patient Name _____ Date of Birth: _____ (mm/dd/yyyy)

Family History

Please check below any problems that family members have had. If known, please state age at which they had a problem.

▢ I was adopted and do not know my family history.

	Mother	Father	Sibling	Child	Grandparent	Other Relative
Alive? (yes, no or N/A)						
Anesthesia Problems						
Alcoholism						
Bleeding Disorder						
Cancer (Type?)						
Heart Disease						
Hearing Loss						
Migraine						
Stroke						
Other						

Review of Systems Please circle any current problems/symptoms or write in unlisted problems/symptoms:

Constitutional	fevers; chills; night sweats; dizziness; fatigue; weight loss
Cardiovascular	chest pain; swelling of extremities; high blood pressure; irregular heart beat; syncope
Endocrine	diabetes; thyroid disease; cold intolerance; poor wound healing
Eyes	blurry vision; double vision; itchiness; blindness; photophobia
Gastrointestinal	nausea; vomiting; bleeding; liver disease; diarrhea
Respiratory	asthma; pneumonia; cough; sputum; wheezing; tuberculosis; coughing up blood; shortness of breath
Genitourinary	bleeding; burning with urination; kidney stones; prostate problem; kidney disease
Hematologic	easy bruising; anemia; clotting disorder; deep venous thrombosis
Immunologic/Lymphatic	HIV positive; AIDS; immunosuppressed; swollen lymph glands; lumps
Musculoskeletal	pain; swelling; weakness; stiffness; arthritis; autoimmune disease
Neurological	numbness; memory problems; vertigo; stroke; seizures; paresthesias (burning or prickling sensation)
OB/Gyn (females only)	pregnant; irregular periods; discharge
Psychiatric	depression; anxiety; hallucinations; suicidal tendency; drug addiction; eating disorder
Skin	rash; lesion; pain

Person completing these forms (print): _____ Date: _____

APS GENERAL CONSENT and AUTHORIZATION FOR TREATMENT

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize the physicians, house staff, nursing, paramedic and allied health professional staff, assisted by the employees of WMCHealth Advanced Physician Services, PC (APS), to provide medical treatment to me or the above named patient. I agree to diagnostic tests and procedures, including X-rays and the administration/injection of pharmaceutical products and medication, in addition to the drawing of blood. I understand and authorize the administration of pharmaceutical agents and medications. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination at APS.

RELEASE OF MEDICAL INFORMATION: I hereby authorize and direct APS and my attending physician to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors.

ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT AND FINANCIAL ASSISTANCE PROGRAM: I hereby assign to APS any and all rights, title, and interest that I have in any insurance proceeds or benefits payable to me or on my behalf for services rendered to me by APS, whether such services are considered in-or out-of-network with respect to any third party payor. I therefore hereby authorize and direct my insurance carrier and/or health care plan to make payment of any and all such amounts directly to APS, rather than to myself or any other insured. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-certification for services. I understand that I am financially responsible to APS for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or in my behalf. If treatment has been given in accordance with New York State's No-Fault Law, it is understood that my liability is limited to charges authorized under such law and applicable New York State No-Fault Fee Schedules. As part of APS's commitment to serving the community it recognizes that it is sometimes necessary to provide care to the uninsured or underinsured patients who cannot afford to pay for care according to established hospital guidelines. WMC has a Financial Assistance Program for patients who financially qualify. Please ask for more details.

CONSENT TO RECEIVE TELEPHONE CALLS, TEXTS AND EMAILS: I hereby consent to APS or a business associate (s) of APS to contact me by voice call, postal mail, text message and/or email at the Account contact homes address, telephone number (s), and Email address (es) reflected on my account. I understand that, by giving this consent, APS may contact me about my medical care or my account, such as but not limited to, appointment, the results of any tests or procedures, business operations, quality reporting, billing, the repayment or collection of amount due and that these calls may be using automatic dialers or pre-recorded voice messages. I further understand and agree that, if the Account contact telephone number (s) or email address (es) provided are for a cellular telephone or other services that charge me in any way for calls or messages received (for example, per minute, per message, per unit of data received or otherwise), I am solely responsible for any charges incurred under my agreement with my cellular telephone or other service provider.

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Advanced Physician Services
Westchester Medical Center Health Network

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: By signing below, I acknowledge receipt of the Notice of Privacy Practices, which outlines how health information about me may be used or disclosed by APS, and how I may obtain access to and control this information. I acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

ACKNOWLEDGEMENT OF RECEIPT OF IMPORTANT INFORMATION ABOUT PAYING FOR YOUR CARE: By signing below, I acknowledge receipt of the important information about paying for your care.

RELEASE OF LIABILITY FOR PERSONAL PROPERTY: I understand and agree that personal property (i.e. money, jewelry) should not be brought into the private practice and agree that APS shall not be liable for loss or damage to any personal property.

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE

Signed: _____
Patient

Signed: _____
Legal authorized Representative

Witness: _____

Date: _____Time: _____

TELEPHONE CONSENT IF GRANTED BY (if required)

Signed: _____
Name of legal representative and relationship to patient.

Signed: _____
Signature of caller.

Witness: _____

Date: _____Time: _____

Patient Signature: _____ Date: _____ Time: _____

APS MEDICATION AUTHORIZATION CONSENT FOR MEDICATION HISTORY ACCESS

MEDICATION AUTHORIZATION:

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies, contribute to the collection of this history. Medication history is important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

The medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I hereby authorize Westchester Medical Center Advanced Physicians Services PC to electronically obtain my medication history from my pharmacy, my health plans, and my other healthcare providers, so that it may be included as part of my electronic health record.

Please carefully read the information carefully before making your decision.

_____I GIVE CONSENT to access my electronic medication history in connection with providing me any health care services, including emergency care.

____ I DENY CONSENT to access my electronic medication history for any purpose, even in a medical emergency.

Please refer to Westchester Medical Center Health Network's Notice of Privacy Practice for any questions regarding your personal health information.

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Advanced Physician Services
Westchester Medical Center Health Network

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE

Signed: _____
Patient

Signed: _____
Legal authorized Representative

Witness: _____

Date: _____Time: _____

TELEPHONE CONSENT IF GRANTED BY (if required)

Signed: _____
Name of legal representative and relationship to patient.

Signed: _____
Signature of caller.

Witness: _____

Date: _____Time: _____

Signature: _____ Date: _____ Time: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
WMC Advanced Physician Services, PC, 19 Bradhurst Ave., Suite 3100N, Hawthorne, NY 10532

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____
  _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**