WELCOME

222Route 299 Highland, NY 12528
845-691-DOCS (3627)

Patient #__________ Arrival Time__________

PATIENT INFORMATION Date __________

Name ______________________________

Street______________________________

City,State,Zip______________________________

Home Phone # ______________________________

Cell Phone #______________________________

Cell Phone Carrier ______________________________

SEX: ☐ M ☐ F Birth date______________ Age______

☐Single☐Married☐Partnered☐Widowed☐Separated☐Divorced

SS# ______________________________

Race ☐ White ☐ Black/African American ☐Asian ☐Other
Ethnicity ☐Hispanic Origin ☐ Non Hispanic Origin
Language ☐ English ☐ Other ______________

Occupation/ Employer ______________
Email Address *(for health newsletter & medical alerts)*

____

Primary Care Physician ______________

Address______________________________

Local Pharmacy ______________

Address______________________________

How did you hear about us? ______________

Please complete the reverse side of this form

In case of emergency contact:

Name______________________________

Address______________________________

______________Relationship______________

Home ______________ Cell______________

ARE WE ABLE TO RELEASE YOUR HEALTH INFORMATION TO THIS PERSON? ______YES ______NO, EMERGENIES ONLY

SELF PAY PATIENTS ONLY: By signing below I certify that I do not currently have health care insurance.

x______________________________

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Insurance Co. ______________________________

Group # ______________ID#______________

Policy Holders Name______________________________

Date of Birth ______________ SS# ______________

Relationship to Patient______________________________

Is patient covered by additional Insurance? YES ☐ NO ☐

SECONDARY INSURANCE INFORMATION

Insurance Co. ______________________________

Group # ______________ID#______________

Policy Holders Name______________________________

Date of Birth ______________SS#______________

Relationship to Patient______________________________

Medical History

Patient Name:___________________________

Primary reason for your visit today____

Check all symptoms that apply for today's visit

☐Aches/Pains	☐Eye Irritation	☐Nose Bleeds	**MEN**
☐Bloating	☐Fatigue	☐Painful Urination	☐Erection Difficulty
☐Blood in Urine	☐Fever	☐Poor Appetite	☐Lump in Testicles
☐Blurred Vision	☐Frequent Urination	☐Poor Circulation	☐Penis Discharge
☐Change in Moles	☐Headache	☐Rash	☐Sore on Penis
☐Chest Pain		☐Rectal Bleeding	**WOMEN**
			☐Abnormal Pap
			☐Bleeding between periods
☐Congestion	☐Hemorrhoids	☐Sinus Problems	☐ Breast Lump
☐Chills/Sweats	☐Heart Palpitations	☐Sore Throat	☐ Vaginal Discharge
☐Constipation	☐Hives	☐Sore that will not heal	Currently Pregnant? ☐YES
☐Cough	☐Hoarseness	☐Stomach Pain	Date of last Period
	☐Itching	☐Swelling of Extremities	_______________
☐Diarrhea	☐Loss of Hearing	☐Vomiting	Date of last PAP
☐Dizziness/Fainting	☐Loss of Sleep	☐Other_____________	_______________
☐Ear Ringing	☐Loss/Gain Weight		Date of last Mammogram
☐Earache/Discharge	☐Nausea		__________________

List any medications you are currently taking: ____________
____
____

List any allergies to medications or substances that you have:
____
____

Check which substances you use and how much you use them.

☐Caffeine________ ☐Drugs_______ ☐Tobacco_______
☐ Alcohol_________ ☐Other______________________

Check if your work exposes you to any of the following:
☐Stress ☐Heavy lifting ☐ Hazardous Substances
☐Other ______________________________________

PAST MEDICAL HISTORY **(Check all that apply for yourself)**

☐AIDS	☐Breast lump	☐Diabetes	☐Hepatitis	☐Kidney Disease	☐Pacemaker	☐Stroke
☐Appendicitis	☐Cancer - Type_______________		☐Epilepsy	☐Herpes	☐Liver Disease ☐Pneumonia	☐Thyroid Problems
☐Arthritis	☐Cataracts	☐Emphysema	☐High Cholesterol	☐Measles	☐Polio	☐Tuberculosis
☐Asthma	☐Chemical Dependency	☐Glaucoma	☐High Blood Pressure	☐Migraine Headaches	☐Prostate Problems	☐Ulcers
☐Alcoholism	☐Chicken Pox	☐Heart Disease	☐HIV positive	☐Multiple Sclerosis	☐Rheumatic Fever	☐Venereal Disease
☐Bleeding disorder	☐COPD	☐Mumps	☐Scarlet Fever			

Last Physical Exam________________________ **Past Surgeries** ____

FAMILY HISTORY

Father ☐ Alive ☐ Deceased Present Health or cause of death ______________________________________
Mother ☐ Alive ☐ Deceased Present Health or cause of death ______________________________________
Brothers No. Alive_____ Health ___________________No. Deceased_______ Cause of death _________________
Sisters No. Alive_____ Health ___________________No. Deceased_______Cause of death _________________
No. of Children______ Name(s) and age____
____
Have any of the above persons have or have had any of the following conditions: ☐Diabetes☐Cancer☐ Heart disease
☐Stroke ☐High blood pressure☐Nervous illness☐Bleeding tendency☐Nervous illness☐Allergy☐kidney disease☐other_______

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE____**DATE**_________________________________