WELCOME

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

Patient #_____ Arrival Time_____

PATIENT INFORMATION

Date _____

Name _____

Street_____

City,State,Zip_____

Primary Phone # _____

Alt Phone #_____

SEX: ☐ M ☐ F Birth date_____ Age_____

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

SS# _____

Ethnicity ☐Hispanic Origin ☐ Non Hispanic Origin
Race ☐ White ☐ Black/African American ☐Asian ☐Other
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
☐Bloating
☐Blood in Urine
☐Blurred Vision
☐Change in Moles
☐Chest Pain
☐Congestion
☐Chills/Sweats
☐Constipation
☐Cough
☐Diarrhea
☐Dizziness/Fainting
☐Ear Ringing
☐Earache/Discharge
☐Eye Irritation
☐Fatigue
☐Fever
☐Frequent Urination
☐Headache
☐Hemorrhoids
☐Heart Palpitations
☐Hives
☐Hoarseness
☐Itching
☐Loss of Hearing
☐Loss of Sleep
☐Loss/Gain Weight
☐Nausea
☐Nose Bleeds
☐Painful Urination
☐Poor Appetite
☐Poor Circulation
☐Rash
☐Rectal Bleeding
☐Sinus Problems
☐Sore Throat
☐Sore that will not heal
☐Stomach Pain
☐Swelling of Extremities
☐Vomiting
☐Other_____

MEN

☐Erection Difficulty
☐Lump in Testicles
☐Penis Discharge
☐Sore on Penis

WOMEN

☐Abnormal Pap
☐Bleeding between periods
☐ Breast Lump
☐ Vaginal Discharge
Currently Pregnant? ☐YES
Date of last Period
_____
Date of last PAP
_____
Date of last Mammogram
_____

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_____