NAME: _____

BIRTHDATE: _____ SS# _____

ADDRESS: _____

CITY: _____ STATE: _____

ZIP CODE: _____ HOME PHONE: _____

WORK PHONE: _____ MAY WE CONTACT YOU AT WORK? Y N

CELL PHONE: _____ OCCUPATION: _____

EMAIL: _____ SEX: M F MARITAL STATUS: M S D W

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE#: _____

Eastern Long Island Family Medicine, P.C.

Christopher Ng, M.D.
Diplomate of the American Board of Family Medicine
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100 South Jersey Ave . Suite 14 . Setauket, New York 11733 . (631)751-3883 . Fax (631)751-3909

1. I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Notice" which describes the Practice's obligation to ensure the privacy of my health information. The HIPAA Privacy Notice describes how the Practice may use and disclose my health information for treatment, payment, and healthcare operations. I know that I have the right to review the Practice's HIPAA Privacy Notice prior to signing this consent.
2. I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future, and that I can receive a copy of the current policy any time by contacting the office.
3. I understand that I have the right to request that the Practice restrict its uses and disclosures of my health information for treatment, payment, or healthcare operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my restrictions.
4. By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment, and healthcare operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance on this consent.

_____ _____
Signature of patient or patient's representative Date

I wish to be contacted in the following manner:

____ Home telephone _____
____ O.K. to leave message with detailed information
____ Leave message with call back number only

____ Work telephone _____
____ O.K. to leave message with detailed information
____ Leave message with call back number only

List here any individuals we may release medical information to:

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on actions already taken prior to the revocation.

AHA/ACSM Health/Fitness Facility Preparticipation Screening Questionnaire

Assess your health status by marking all *true* statements

History

You have had:

____a heart attack
____heart surgery
____cardiac catheterization
____coronary angioplasty (PTCA)
____pacemaker/implantable cardiac
____defibrillator/rhythm disturbance
____heart valve disease
____heart failure
____heart transplantation
____congenital heart disease

Symptoms

____You experience chest discomfort with exertion.
____You experience unreasonable breathlessness.
____You experience dizziness, fainting, or blackouts.
____You take heart medications.

Other health issues

____You have diabetes.
____You have asthma or other lung disease.
____You have burning or cramping sensation in your lower legs when walking short distances.
____You have musculoskeletal problems that limit your physical activity.
____You have concerns about the safety of exercise.
____You take prescription medication(s).
____You are pregnant.

If you marked any of these statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with a **medically qualified staff.**

Cardiovascular risk factors

____You are a man older than 45 years.
____You are a woman older than 55 years, have had a hysterectomy or are postmenopausal.
____You smoke or quit smoking within the previous 6 months.
____Your blood pressure is >140/90 mm Hg.
____You do not know your blood pressure.
____You take blood pressure medication.
____Your blood cholesterol level is > 200 mg/dL.
____You do not know your cholesterol level.
____You have a close blood relative who had a heart attack guide your exercise program. or heart surgery before age 55 (father or brother) or age 65 (mother or sister).
____You are > 20 pounds overweight.
____You are physically inactive (i.e., you get<30 minutes of physical activity on at least 3 days per week.

If you marked two or more of the statements in this section, you should consult your physician or other appropriate health care provider before engaging in exercise. You might benefit from using a facility with a professionally qualified exercise staff to guide your exercise program.

___ None of the above — You should be able to exercise safely without consulting your physician or other appropriate health care provider in a self- guided program or almost any facility that meets your exercise program needs

Medical History

NAME DATE AGENCY

BADGE NUMBER _____ DOB _____ AGE _____ NEW MEMBER _____

ADDRESS _____ TOWN _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PERSONAL PHYSICIAN _____ OCCUPATION _____

EMAIL ADDRESS _____

Allergy	Type of Reaction
_____	_____
_____	_____
_____	_____

Past Medical History

Please circle any conditions you have had in the past or are currently experiencing:

High Blood Pressure	Bronchitis	Change in bowel habits	Arthritis
Diabetes	Pneumonia	Unexplained weight	Low back problems
Cancer	Persistant cough	gain/loss?	Skin diseases
Heart disease	T.B.	Hemmorrhoids	Blood disorder
Chest pain/tightness	Hay fever	Gall Bladder disease	Venereal disease
Shortness of breath	Abdominal pain	Colitis	Anxiety
Swollen ankles	Indigestion	Hepatitis or jaundice	Depression
Palpitations	Nausea	Thryoid disease	Anemia
Lightheadedness	Vomiting	Alcohol abuse	Frequent Urination
Constipation	Headache	Drug abuse	Rheumatic fever
Diarrhea	Seizures	Asthma	Blood in stool
Kidney stones	Gout	Ulcers	Difficulty urinating
Impotence or erectile dysfunction	Insomnia	Kidney Problems	Heart Problems
Lung Problems	Vision Problems	Wear contacts/glasses	Hearing problems
Wear Hearing Aid	Smoke/ use tobacco products		High cholesterol

Have you ever had an injury or illness which caused loss or permanent impairment of a "paired organ)? Yes No

(arms, legs, ears, eyes, overies, testis, kidneys, or lungs)

Do any of your "blood" relatives have high blood pressure, diabetes, cancer, or heart disease? Yes No

Have you ever worked with chemicals, asbestos, or other hazardous materials? Yes No

Please list any other problems, or explinations for any that were circled:

_____

_____

_____

_____

_____

Female members

Are your menstrual periods regular? Yes No

Have your pap tests and mammograms always been normal? Yes No

What was the date of your last pap test? _____

What was the date of your last menstrual period? _____

What was the date of your last mammogram? _____

HAVE YOU HAD ANY HOSPITALIZATIONS OR BEEN TAKEN OUT OF SERVICE SINCE YOUR LAST VISIT HERE?

Yes No

If yes, please explain _____

_____

_____

_____

PAST SURGERIES

Type of surgery	Date of surgery

Medication List (list all supplements, OTC drugs, vitamins, and prescription medication)

Name of medication	Dosage and Frequency

Other Physicians Treating You (for example: GYN, Cardiologist, Eye Doctor, etc.)

Name and Specialty	Reason For Treatment	Providers Phone#

Preventative medicine

Please circle any immunizations you have had and date administered:

Hepatitis B _____ Flu immunization _____ Tetanus immunization _____

Pneumovax _____ Prevnar _____ PPD _____

SELDEN FIRE DISTRICT

1910.1030 App A - Hepatitis B Vaccine Declination
(Mandatory)

I _____understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection.

I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself.

However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____
(Members Signature) (Date)

_____ _____
(Dr Christopher Ng) (Date)

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:

8. Name and address of person(s) or category of person to whom this information will be sent:
Christopher Ng, M.D. 100 South Jersey Ave Suite 14 Setauket NY 11733 Fax (631)751-3909

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.**