Eastern Long Island Family Medicine, P.C.
Christopher Ng, M.D.
Diplomate of the American Board of Family Medicine
Assistant Professor, SUNY Stony Brook, Department of Family Medicine
100 South Jersey Ave . Suite 14 . Setauket, New York 11733 . (631)751-3883 . Fax (631)751-3909

New Patient Packet

NAME: _____

BIRTH DATE: _____ SS# _____

ADDRESS: _____

CITY: _____ STATE: _____

ZIP CODE: _____ HOME PHONE: _____

WORK PHONE: _____ MAY WE CONTACT YOU AT WORK?

CELL PHONE: _____ OCCUPATION: _____

EMAIL: _____ SEX: MARITAL STATUS:

PRIMARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

POLICY HOLDER SS# _____ RELATIONSHIP TO INSURED: _____

POLICY HOLDER EMPLOYER: _____

SECONDARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

POLICY HOLDER SS# _____ RELATIONSHIP TO INSURED: _____

POLICY HOLDER EMPLOYER: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE#: _____

We require 24 hours' notice for an appointment cancellation. If notice is not received, you will be subject to a $50 fee. There is also a $10 administrative fee for copays not paid at the time of service.

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I authorize my physician to mark the section "ENROLLEE'S OR AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE". This authorizes the release of medical information to my insurance carrier or other third party which is necessary to process medical claims. It also authorizes payment of medical benefits directly to the physician.

PATIENT'S SIGNATURE _____ DATE_____

LOCAL PHARMACY: _____ PHONE#: _____

ADDRESS: _____

MAIL ORDER PHARMACY: _____ PHONE #: _____

ADDRESS: _____

By signing this consent form you are agreeing that Eastern Long Island Family Medicine can request, view, and use your prescription medication history from other healthcare providers and third parties such as, but not limited to, pharmacies, benefit payers, and government databases.

Understanding all the above, I hereby provide informed consent for Eastern Long Island Family Medicine to obtain my prescription history.

PATIENT'S SIGNATURE _____ DATE_____

NYSIIS (New York State Immunization Information System)

We are required to report all immunizations given to anyone under the age of 18 to NYSIIS. Those 18 and older require us to collect authorization from the patient.

I give Christopher Ng M.D. and Eastern Long Island Family Medicine consent to report any immunizations administered to the New York State Immunization Information System.

_____ _____

Signature Mother's maiden name (optional, for identification purposes)

MEDICARE PATIENTS ONLY:

Eastern Long Island Family Medicine participates in a Medicare Shared Savings Program Accountable Care Organization. ACOs are groups of doctors and other health care providers who voluntarily work together with Medicare to give you high quality service and care at the right time in the right setting. An ACO is not a Medicare Advantage Plan, or an insurance plan. ACOs don't change your Medicare benefits. To help you get better, more coordinated care, Medicare will share certain health information with us about the care you get from your doctors and other health care providers.

Initial here to acknowledge that you are aware of our participation in an ACO: _____

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Patients are responsible for payment for any visit or procedure that their insurance company does not cover including, but not limited to the following:

- Not notifying your insurance company that Dr. Christopher Ng is your Primary Care Physician.
- Not informing Eastern L.I. Family Medicine of any change in insurance.
- Insurance company does not cover you to have a procedure/office visit done at this office.
- You had a procedure/office visit done more frequently than your insurance company allows.
- A certain procedure/office visit is not a covered benefit under your policy. (Medicare patients, please be aware that physicals are not covered by Medicare. If you have one, you will be responsible for the charges.
- We do not participate with your insurance company, their administrator, or a particular plan your insurance company offers.

If you would like to check with your insurance company before having a procedure, please let us know so we can supply you with procedure codes.

If you are switching insurances, or plans, please let us know so we can supply you with our provider number. You will need this to verify with your insurance company that we are participating. You will also need this number if you are required to list a Primary Care Physician.

There is a $50 fee for missed appointments. We confirm appointments as a courtesy only. It is the patient's responsibility to call and cancel if they are unable to make their appointment.

I have read and understand the above.

_____ _____

Signature Date

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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 _____ ____ Work telephone _____

____ O.K. to leave message with detailed information ____ O.K. to leave message with detailed information

____ Leave message with call back number only ____ 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.

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Medical History

Name: DOB: Date:

Preferred laboratory? Please select one:

Allergy Check if none Type of Reaction

_____ _____

_____ _____

_____ _____

_____ _____

Please check any conditions you have had in the past or are currently experiencing: Check if none

High Blood Pressure	Bronchitis	Change in bowel habits	Arthritis
Diabetes	Pneumonia	Unexplained weight gain/loss?	Low back problems
Cancer	Persistent cough		Skin diseases
Heart disease	T.B.	Hemorrhoids	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	Thyroid disease	Anemia
Lightheadedness	Vomiting	Alcohol abuse	Frequent Urination
Constipation	Headache	Drug abuse	Rheumatic fever
Diarrhea	Kidney disease	Asthma	Blood in stool
Kidney stones	Gout	Ulcers	Difficulty urinating
Impotence or erectile dysfunction			

Please list any other problems, or explanations for any that were checked:

_____

_____

_____

_____

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Gynecologic and Obstetric History

If male, skip this section

Age at onset of periods _____ Frequency _____ Length of period _____

Pregnancies _____ Births _____ Miscarriages _____

Prolonged or abnormal bleeding? If yes, describe:_____

Leakage of urine? If yes, describe:_____

Pelvic pain? If yes, describe:_____

Abnormal discharge? If yes, describe:_____

History of abnormal pap? If yes, describe:_____

Are you in menopause? Date of last menses?:_____

Surgical History/Hospitalizations

Check if none

Hospital Visits (what for?)	What Hospital?	Date of Hospital Visit
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries (What procedure?)	Where?	Date of Surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Check if none

Name of medication	Dosage and Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Physicians Treating You (for example: GYN, Cardiologist, Eye Doctor, etc.) Check if none

Name and Specialty	Reason For Treatment	Provider's Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list your previous primary care physician: Check if none

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Preventative medicine

Please check any immunizations you have had, and date administered:

Hepatitis B _____Date:_____ Flu immunization _____ Date:_____

Tetanus immunization _____ Date:_____ Pneumovax _____ Date:_____

Prevnar _____ Date:_____ Other _____ Date:_____

Which of the following have you had:

Procedure	When?	What office/facility was it done?
Pap smear		
Mammogram		
Breast exam		
Cholesterol check		
Colonoscopy		
Prostate exam		
Dexa scan		
Eye exam		

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Do you wear seatbelts?		
Do you wear a bicycle helmet?		
Do you exercise regularly?		If yes, what type, how often?
Do you smoke?		If yes, how many daily?
Do you drink alcohol?		If yes, how much per week?
Do you drink coffee or tea?		If yes, how many cups daily?
If there is a gun in your home, do you keep it unloaded and out of children's reach?		
Do you use drugs?		If yes, explain:
Have you ever engaged in activity which has put you at risk for AIDS?		If yes, would you like to be tested for AIDS?
Have you ever worked with chemicals, asbestos, or other hazardous materials?		If yes, please explain:
Are you in a relationship in which you have been physically hurt by your partner?		
Do you have a living will?		
Do you have a donor card?		
What method of birth control do you use?		

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Check off all boxes that correlate with your farmily history:

Family History							
	Self	Father	Mother	Sisters	Brothers	Daughters	Sons
Breast cancer							
Hypertension							
Heart Disease							
Stroke Kidney							
Disease Obesity							
Genetic disorder							
Alcoholism Liver							
Deceased Disease							
Depression							
Colon/rectal cancer							
Other cancer							
Other:							

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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.**

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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

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 Dr. Christopher Ng _____

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.**