Northwell Health℠
Physician Partners

Patient Name: _____ **DOB:**_____

Patient Intake and History Form

Please provide the following information. This form is confidential and will be entered into your medical record.

Past Medical History *Please check any condition you have now or have had in the past* ☐**No Past Medical History**

☐Asthma	☐Cancer(type_____)	☐Arthritis (location_____)
☐COPD	☐Neuropathy	☐Herniated Disc
☐Diabetes	☐Parkinson's Disease	☐Lupus
☐Heart Disease	☐Prolonged Steroid Treatment	☐Osteoporosis
☐ High Cholesterol	☐Seizure/Epilepsy	☐Rheumatoid Arthritis
☐ Hypertension	☐Stroke	☐Spinal Stenosis
Other_____	Other_____	Other_____

Surgery and Hospitalization History ☐**No Past Surgery/Hospitalizations**

Reason for Surgery/Hospitalization	Hospital Name (if available)	Date (approximate)

Family History *Have any family members had the following?* ☐**No Pertinent Family History**

	Yes	No	If Yes, who?	Type	Location
Arthritis/DJD					
Cancer					
Genetic Disease					
Osteoporosis					

Social History

Living Situation	☐ Alone ☐ Family	☐ House ☐ Apartment ☐ Stairs	
Occupation		Currently Working? ☐ Yes ☐No	
Smoking Hx	☐ Current Smoker:	*packs per day*? ☐ <1 ☐ 1-2 ☐ 3+	
		how long? ☐ < 1 year ☐ 1-10 years ☐ 10+years	
	☐ Former Smoker	☐ Never a Smoker	
Do you drink alcohol?	☐Regularly ☐Occasionally	☐ Rarely ☐ Never	*If Yes, have you ever been treated* ☐ Yes ☐No
Do you use recreational drugs?	☐Regularly ☐Occasionally	☐ Rarely ☐ Never	*If Yes, have you ever been treated* ☐ Yes ☐No
Do you exercise?	☐Regularly ☐Occasionally	☐ Rarely ☐ Never	Intensity ☐ High ☐ Low
List Activities			

Patient Name: _____ **DOB:**_____

Allergies *Please check all that apply* ☐**No Known Allergies**

☐ Shellfish ☐ Contrast Dye ☐ Latex ☐Medications _____
☐ Seasonal ☐ Latex ☐ General/Local Anesthetic ☐ Other _____

Current Medications *Please list all medications including vitamins and supplements* ☐**No Current Medications**

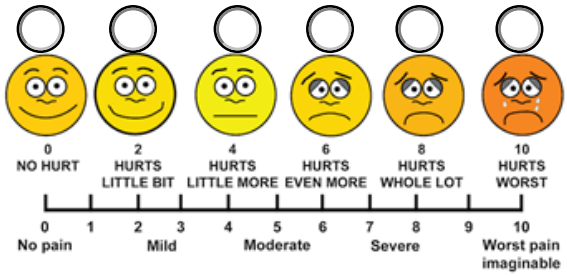
1.	2.	3.
4.	5.	6.

Have you recently taken or used? ☐ NSAIDS (Aleve, Ibuprofen, Aspirin) ☐ Tylenol ☐ Ice/Compression ☐ Other OTC

Reason for you visit today: _____

Current Height: _____ft _____in Current Weight: _____lbs

Pain Assessment *Please circle the picture/number to describe the severity of your pain at this time.*



Location of Pain: _____

Describe Your Pain ☐ intermittent ☐ constant ☐ localized ☐ radiating ☐ other _____

How long have you had pain? ___Days ____Weeks ____Months ____Years

Review of Systems *Please check any of the following symptoms you have experienced recently or are experiencing now*

☐Chills	☐Feeling Tired	☐Fever	☐Recent Weight Gain
☐Discharge	☐Eye Pain	☐Sight Problems	☐Redness
☐Dec Hearing	☐Nasal Discharge	☐Nosebleeds	☐Sore Throat
☐SOB at rest	☐Cough	☐SOB w/exertion	☐Leg Swelling
☐Abdominal Pain	☐Constipation	☐Diarrhea	☐Heartburn
☐Urinary Frequency	☐Urinary Urgency	☐Incontinence	☐Abnormal. Vaginal Bleeding
☐Arthralgias	☐Joint Pain	☐Joint Stiffness	☐Joint Swelling
☐Breast Pain	☐Breast Lump	☐Skin Lesions	☐Change in a mole
☐Headache	☐Dizziness	☐Fainting	☐Convulsions
☐Anxiety	☐Depression	☐Sleep Disturbances	☐Muscle Weakness
☐Deepening Voice	☐Feeling Weak	☐Hot Flashes	
☐Easy Bleeding	☐Easy Bruising	☐Swollen Glands	

_____
Signature of Patient Date

_____
Patient Representative Name Signature Date

Northwell Health℠
Physician Partners

Patient Name: _____ DOB:_____

Pharmacy Update

*In order to serve you better, please **PRINT** and complete all applicable information*

Pharmacy Information:

Name:_____ Phone: _____ Fax: _____

Address:_____

Mail Order Pharmacy Information:

Name:_____ Phone: _____ Fax: _____

Address:_____

Prescription Benefit Plan

Name:_____ Phone: _____ Fax: _____

Address:_____

Member #: _____ Group #_____

Please provide the front desk with a copy of your prescription benefit plan card if applicable

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Patient Name: _____ DOB:_____

In order to serve you better please answer the following questions.

**Note: Definitions are available below for reference.*

Did your injury occur at work? ◯**Yes** ◯**No**

***If yes*, do you have an ACTIVE Workers Compensation case?** ◯**Yes** ◯**No**

Did your injury occur due to a Motor Vehicle Accident ◯**Yes** ◯**No**

***If yes*, do you have an ACTIVE No Fault case?** ◯**Yes** ◯**No**

Workers Compensation:

Workers' compensation is insurance that provides cash benefits and/or medical care for workers who are injured or become ill as a direct result of their job. Employers pay for this insurance, and shall not require the employee to contribute to the cost of compensation. Weekly cash benefits and medical care are paid by the employer's insurance carrier, as directed by the Workers' Compensation Board. The Workers' Compensation Board is a state agency that processes the claims. If Board intervention is necessary, it will determine whether that insurer will reimburse for cash benefits and/or medical care, and the amounts payable.

Your injury should be covered under Workers Compensation if:

- You were injured on the job.
- You were injured while traveling on business.
- You were doing a work-related errand.
- You were attending a required business-related social function.
- If your job requires you to drive a motor vehicle and you were hurt in an accident.

No Fault

A no fault insurance claim, sometimes called a Personal Injury Protection claim (or PIP claim), is one you make against your own automobile insurer for payment of medical bills and lost earnings under New York's no fault laws. Your insurer will pay your medical bills and will reimburse you for some of all of your lost earnings up to the amount of your claim or New York's no fault limit, whichever is lower. Once your medical bills exceed New York's no fault limit, you are responsible for paying them. If you have health insurance, your health insurer will pay your medical bills from that point on. If you are on Medicare or a state run health insurance program through Medicaid, those entities will pay the bills. If you do not have health insurance, Medicare, or Medicaid, then you are responsible for working out payment arrangements with your health care providers.

Your injury should be covered under No Fault if:

- The accident occurred in New York.
- The injured party was the driver or passenger of the insured vehicle or a cyclist or pedestrian struck by or in contact with the motor vehicle.
- The vehicle caused the injury, for example: a motor vehicle accident, a parked car causes bodily harm, etc.
- The vehicle must be a car, truck, bus, taxi (not a motorcycle) or other vehicle covered by New York No-Fault law.
- The vehicle is registered in New York.
- The vehicle has an insurance policy sold in New York or issued by a company licensed to do business in the State of New York.

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Authorization for Release of Health Information Pursuant To HIPAA

PATIENT NAME (PRINT)	DATE OF BIRTH
PATIENT ADDRESS AND TELEPHONE NUMBER	

I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed 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 8(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 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol, drug treatment, or mental health related 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. Name and address of health care provider or entity to release this information:

6a. If you are requesting only laboratory results directly from North Shore-LIJ Laboratories, enter "North Shore-LIJ Laboratories" above. Provide the following information and then go directly to Sections 7, 9, 10, 11 and 12 and sign as indicated below item 12.

Ordering Physician's Name: _____
Information to Be Released: Laboratory testing results
Date Of Service: _____/_____/_____

Authorized Recipient:	Patient	Patient's Designee (or parent of unemancipated minor patient) Name of Designee _____

Consulting Physician: Name: _____ Telephone: (_____) _____
Address: _____

The laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of laboratory results. All questions regarding testing and the results will be answered by the PATIENT'S PHYSICIAN ONLY. Reports will generally be available 4 days after ALL laboratory test result are complete.

Result option (select one) _____ ☐ Mail _____ ☐ Fax _____ ☐ Pick-Up (at any Patient Service Center)

Patient or Representative Initials: ☐

Copy 1 – Patient Medical Record
Copy 2 – Patient or Patient's Personal Representative

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Authorization for Release of Health Information Pursuant To HIPAA

7. Name, address, telephone and fax numbers of person(s) or category of person to whom this information will be sent:

8. (a).Specific information to be released:

Medical Record Abstract — Medical Record from (insert date) _____ to (insert date) _____

Designated Record Set — Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals and consults.

Other: _____
_____

Include: (Indicate by initialing)
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Related Information**
___ ___ **HIV-Related Information**

8. (b).**Authorization to Discuss Health Information**

By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with the individual listed: _____
Individual Name

9. Reason for release of information:
At request of individual
___ Other: _____

10. Date or event on which this authorization will expire:

11. Printed name and signature of person signing form:

12. Authority to sign on behalf of patient or relationship to 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.

Patient/Agent/Relative/Guardian* (Signature) Date / Time — Print Name Relationship if other than patient

Telephonic Interpreter's ID # Date / Time
OR
Signature: Interpreter Date / Time — Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature) Date / Time — Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

*** 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.**

Internal Use Only - Student Immunization Authorization Consent provided by
Consent provided by: _____ Relationship to Patient: _____
Name of HIM Staff Member who obtained verbal consent: _____ Date Processed: _____
Internal Use Only - For North Shore-LIJ Laboratories Use Only:
Date: ____/____/____; Time: ____:____; Personnel Name: _____; Accession #: _____

Clear Form Submit Form