Name: _____ **Primary Doctor:** _____**Phone:**_____

Today's Date:_____ **Referring Doctor:** _____**Phone:**_____

Date of Birth: _____ **Age**_____ **How did you find us?**_____

Gender: Male **Marital Status (circle one):** single

Race (select one): Select one

Ethnicity (select one): Select one

Language (select one one): English

Social Security Number: _____ **Primary Address**: _____

_____

Phone Number (1) :_____ **(home) (cell) (work)** Phone Type

Phone Number (2): _____ **(home) (cell) (work)** Phone type

Email Address: _____

Emergency contact: _____ **Phone Number (3):** _____ **(home) (cell) (work)**

Primary Insurance:

Insurance Company: _____ **Address:** _____

ID Number:_____ **City**_____**State** _____ **Zip**_____

Primary Insurance Holder Name: _____ **DOB** _____ **Relationship to Patient**_____

Secondary Insurance:

Insurance Company: _____

ID Number:_____

Primary Insurance Holder Name: _____ **DOB** _____ **Relationship to Patient**_____

***** When was your last blood work (CBC,complete blood count)?*_____ *where?*_____**

***** When was your last EKG (heart test)?*_____ *where?*_____**

*Please give us ***name*** , ***street***, & ***town*** of your pharmacy, for electronic prescriptions

_____

_____

☐ Please also check this box to give us permission to access the electronic pharmacy database

Name:_____ Date_____

Briefly, why are you here today:

_____ *Phys Notes*:

_____

LIST ANY SIGNIFICANT MEDICAL PROBLEMS, AND APPROXIMATE DATE
Check if applicable

- ■ **Hypertension** _____
- ■ **Diabetes** _____
- ■ **Heart problems (be specific)** _____

_____

- □ **Other**_____

_____

_____

LIST ANY SIGNIFICANT SURGERY, AND APPROXIMATE YEAR

_____

_____

_____

Have you had a previous colonoscopy?_____ MUST put approximate date_____
Where was it done?_____ results?_____

Have you had a previous gastroscopy?_____ MUST put approximate date _____
Where was it done? _____ results?_____

Allergies: (circle one) yes/no (please list)

_____

_____

Smoking (circle one): Choose one
If "yes", how long have you been smoking? _____ If "former", how long has it been? _____

Alcohol (circle one): Chose One
Drugs (circle one): Choose one
Do you require antibiotics for invasive procedures or dental work? Choose one

Name:_____ Date_____

REVIEW OF SYSTEMS: CHECK IF APPLICABLE

CONSTITUTIONAL

- □ fever
- □ chills
- □ fatigue
- □ infections
- □ poor sleep
- □ weakness
- □ weight gain
  Obesity
- □ weight loss

RESPIRATORY

- □ asthma
- □ wheezing
- □ snoring
- □ sleep apnea
- □ cough
- □ shortness of breath
- □ positive PPD
  TB exposure

ENDOCRINE

- □ hypothyroid
- □ hyperthyroid
- □ heat intolerance
- □ cold intolerance
- □ high calcium
- □ hyperglycemia/ diabetes
- □ steroid side effects

NEUROLOGIC

- □ loss of consciousness
- □ headache
- □ mental status change
- □ migraines
- □ seizure
- □ TIA/stroke
- □ vertigo
- □ vision change

CARDIOVASCULAR

- □ cardiac stents
- □ pacemaker
- □ defibrillator
- □ heart attack
- □ arrhythmia
- □ Palpitations
- □ irregular heartbeats
- □ heart murmurs

HEMATOLOGIC/ LYMPHATIC

- □ abnormal bleeding or bruising
- □ anemia
- □ eosinophilia (allergic white cells)
- □ leukocytosis, elevated white blood count
- □ lymph node enlargement
- □ low white blood Count-Neutropenia
- □ low platelets thrombocytopenia
- □ venous thrombosis

EYES

- □ cataract
- □ diabetic retinopathy
- □ eye inflammation iritis/uveitis
- □ glaucoma
- □ vision change

PSYCHIATRIC

- □ anxiety
- □ depression
- □ drug abuse
- □ eating disorder anorexia, bulimia
- □ panic attacks
- □ recent stress

MUSCULOSKELETAL

- □ arthritis, joint pain
- □ back pain
- □ knee pain
- □ muscle weakness
- □ osteoporosis
- □ sciatica

FAMILY HISTORY

- □ colon cancer
- □ colon polyps
- □ breast cancer
- □ other cancers
- □ colitis
- □ heart disease
- □ gallstones
- □ liver disease
- □ diabetes
- □ hypertension

GENITOURINARY

- □ renal failure
- □ burning urination urinary infection
- □ bloody urine

DERMATOLOGIC

- □ skin cancer
- □ rash

□ None Apply

Name:_____ Date_____

GASTROINTESTINAL COMPLAINTS: CHECK IF APPLICABLE

□ swallowing problems
□ heartburn
□ ulcers
□ H. pylori Infection
□ abdominal pain
□ nausea
□ vomiting
□ bloating
□ crampy pain
□ diarrhea
□ belching
□ laxative use
□ constipation
□ weight loss
□ weight gain
□ change in bowel habit
□ polyps
□ rectal pain
□ hemorrhoids
□ rectal bleeding
□ positive stool tests for occult blood
□ black tarry stool
□ excessive sugarless candy or gum
□ vomiting blood
□ use of aspirin or anti-inflammatories
□ recent antibiotics
□ foreign travel
□ fatty food intolerance
□ lactose intolerance
□ colitis
□ spicy food intolerance
□ parasites
□ pancreatitis
□ gallstones
□ blood transfusions
□ jaundice
□ hepatitis
□ abnormal liver tests
□ liver disease

Any previous tests and dates?

□ abdominal sonogram _____
□ pelvic sonogram _____
□ CAT scan _____
□ upper GI series _____
□ barium enema _____
□ colonoscopy _____
□ sigmoidoscopy _____
□ liver biopsy _____
□ upper endoscopy / gastroscopy _____
□ other _____

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I authorize direct payment of surgical/medical benefits to Dr. Braunstein for services rendered by him or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I authorize Dr. Braunstein to keep my signature on file for purposes of filing insurance claims. A photocopy of these assignments shall be valid as the original.

X Signature _____Date_____
X Patient Guardian _____Date_____

Name:_____ Date_____

Weight _____lb. Height _____in.

Recent blood pressure: _____/_____ (approximate)

MEDICATION LIST

PLEASE LIST ALL YOUR MEDICATIONS AND DOSAGE

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name:_____ Date_____

ACKNOWLEDGMENT FORM - RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1966 and New York public-health laws I have certain rights to privacy regarding my protected health information. This paragraph is an incomplete and brief listing of my rights. I understand that my health information can and will be used, without further authorization, by the medical-practice of Michael Braunstein M.D. to conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment; obtain payment from third-party payers; conduct normal healthcare operations such as quality of care assessments. I may request in writing that the practice restrict how my private information is used, but I understand that the practice is not required to agree to my requested restrictions. The practice has the right to change its privacy practices. I acknowledge that I have been given the opportunity to review or, if requested, have received a copy of this practice's current more detailed Notice of Privacy Practices.

X Signature: _____ Date: _____

NOTIFICATION POLICY

A $20.00 service charge will be applied to patient account balances not paid within 30 days of receipt of our 1st billing statement. This charge will re-occur monthly until sent to collections.

If we refer your account to a collection agency your account will be increased by 25%. If we refer your account to an attorney your account will be increased by 25% plus court costs.

If you need to cancel your appointment, call us 7 days prior, or a fee of $50 for Procedure and $10 for OV/FU Visit will be incurred. <u>These fees are not covered by your plan.</u>

X Signature: _____ Date: _____

I authorize the staff to leave medical information at the following locations:

Home telephone	**Yes ☐**	**No ☐**
Home answering machine	**Yes ☐**	**No ☐**
Work telephone	**Yes ☐**	**No ☐**
Work voicemail	**Yes ☐**	**No ☐**
Cell phone and voicemail	**Yes ☐**	**No ☐**

I authorize the staff to discuss medical information with the following people:

Name_____ Relationship _____
Name_____ Relationship _____
Name_____ Relationship _____
Name_____ Relationship _____