Name:

Date:

Referring Provider:

What are your concerns for today's visit? _____

LIST ANY ***ALLERGIES TO MEDICATIONS:***

PAST MEDICAL HISTORY:

1) Please check the "YES" or "NO" box to indicate whether you have any of the following illnesses; for "YES" answers, please explain

	Yes	No	Explain		Yes	No	Explain
Diabetes	☐	☐		Stomach or Intestinal Problems	☐	☐	
Hypertension (high blood pressure)	☐	☐		Allergy problems/therapy	☐	☐	
Thyroid Problems	☐	☐		Kidney Problems	☐	☐	
Heart Disease/Cholesterol	☐	☐		Neurological Problems	☐	☐	
Respiratory Problems	☐	☐		Hepatitis	☐	☐	
Other Medical Diagnosis	☐	☐		Immune Deficiency	☐	☐	
Facial Fracture /Trauma	☐	☐					

Exposure to Toxic Chemicals	Y	N	Trauma to Head	Y	N
Loud Blasts or Noise Exposure	Y	N	Family History of Hearing Loss	Y	N

2) Please list any operations (and Dates) you have ever had (including tonsils & adenoids):

Type of surgery	Date of surgery	Hospital or place of surgery

3) Please list any current medications (and amounts, times per day):
(including aspirin, antacids, vitamins, hormone replacements, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds)

SOCIAL HISTORY

	Yes	No	Please list details below:
Do you smoke?	☐	☐	How much? _____ How many years? _____
If no, did you smoke previously?	☐	☐	
Do you drink alcohol?	☐	☐	How much? _____ What type(s) _____
Use of recreational drugs?	☐	☐	How often? _____ What type(s) _____

FAMILY HISTORY

Please check the "YES" or "NO" box to indicate whether any relatives have any of the following illnesses:
If yes, please indicate which relative(s) have the problem.

	Yes	No	
Hearing or balance problems	☐	☐	
Allergy	☐	☐	
Diabetes	☐	☐	
Cancer	☐	☐	
Bleeding Disorder	☐	☐	
Anesthesia problems	☐	☐	
Heart problems	☐	☐	
Other	☐	☐	

REVIEWED BY:

Name:
Chart:
Date:

Please provide the following medical information to the best of your ability:

Review of Systems:

1) Please check the "YES" or "NO" box to indicate whether you presently have any of the following symptoms:
2) For any "YES" response, please check the "Current" box if this symptom relates to the reason for your visit today:

		Yes	No	Current		Yes	No	Current
ALLERGY	Sneezing	☐	☐	☐	Post nasal drip	☐	☐	☐
	Seasonal allergy	☐	☐	☐				
ENT	Ear pain or itch	☐	☐	☐	Ear drainage	☐	☐	☐
	Hearing loss	☐	☐	☐	Ear noises	☐	☐	☐
	Recurrent ear infections	☐	☐	☐	Swelling neck/face	☐	☐	☐
	Dizziness, Vertigo	☐	☐	☐	Lightheadedness	☐	☐	☐
	Nasal congestion	☐	☐	☐	Sinus pressure/pain	☐	☐	☐
	Nose bleeds	☐	☐	☐	Sense of smell problem	☐	☐	☐
	Recurrent sinus infections	☐	☐	☐	Discolored nasal discharge	☐	☐	☐
	Problem snoring	☐	☐	☐	Snoring with pauses	☐	☐	☐
	Hoarseness	☐	☐	☐	Throat pain	☐	☐	☐
	Throat clearing	☐	☐	☐	Throat dryness/itching	☐	☐	☐
RESPIRATORY	Cough	☐	☐	☐	Coughing blood	☐	☐	☐
	Wheezing	☐	☐	☐	Shortness of breath	☐	☐	☐
	Noisy breathing	☐	☐	☐				
EYES	Eye pain	☐	☐	☐	Watery or itchy eyes	☐	☐	☐
GI	Difficulty swallowing	☐	☐	☐	Heartburn, reflux	☐	☐	☐
NEURO	Headache	☐	☐	☐	Passing out	☐	☐	☐
GENERAL	Chills	☐	☐	☐	Weight loss/pain	☐	☐	☐
	Fatigue	☐	☐	☐	Daytime sleepiness	☐	☐	☐
ENDO	Feel warmer than others	☐	☐	☐	Feel cooler than others	☐	☐	☐
HEME/LYM	Swollen glands	☐	☐	☐	Sweating at night	☐	☐	☐
	Bleeding problems	☐	☐	☐	Easy bruising	☐	☐	☐
CARDIAC	Chest pain	☐	☐	☐	Palpitations	☐	☐	☐
MSK	Joint aches	☐	☐	☐	Muscle aches	☐	☐	☐
SKIN	Rash	☐	☐	☐	Hives	☐	☐	☐
	Itching	☐	☐	☐	Skin/hair changes	☐	☐	☐
	Strawberry birth marks							
PYSCH	Depression	☐	☐	☐	Anxiety or panic	☐	☐	☐

REVIEWED BY:

NYU Langone MEDICAL CENTER

Faculty Group Practice Patient Demographic Form

Patient Information

Name (Last, First, MI)			Today's Date
Street Address	City	State	Zip
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	
SSN	Date of Birth	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner ☐ Other
Race	Ethnicity	Preferred Language	Email address

Financially Responsible Party

Is patient responsible party/guarantor? ☐Yes☐No(If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)

Name	Address	City/State/Zip	Relationship to Patient
Occupation	Employer	Email Address	Date of Birth
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	

Emergency Contact

Name		Relationship to Patient
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

Referral Info

Referring Physician's Name	Physician Phone/Fax (if known) ( )
Physician Address	

PCP Info

Primary Care Physician's Name (Check if same as Referring Physician above☐)	Physician Phone/Fax (if known) ( )
Physician Address	

Insurance Information

Primary Insurance Company		Policy #	Group #
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____		Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber / Work Phone ( )
Secondary Insurance Company		Policy #	Group #
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____		Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber / Work Phone ( )

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: ____/____/____

Guarantor Signature (if other than patient): _____ Date: ____/____/____

Form Revised: 10/25/2011

NYU Langone Medical Center Electronic Health Information System

I have received the NYU Langone Medical Center Electronic Health Information System Fact Sheet. It describes (1) the purpose of the NYU Langone Medical Center Electronic Health Information System; (2) how it works; and (3) how the providers participating in the NYU Langone Medical Center Electronic Health Information System will record and access my health information.

I understand that by signing this form, NYULMC providers directly involved in my care may access my health information, including my electronic prescription records, and that it will be available to my other health care providers in the system, as described in the Fact Sheet.

I acknowledge receipt of the Electronic Health Information System Fact Sheet and consent for all of my providers who participate in the NYU Langone Medical Center Electronic Health Information System to create and/or access and use my electronic health record (EHR) in order to provide my medical care. I understand that this consent will remain in effect unless revoked in writing.

_____ _____

Signature of patient or representative authorized by law Date

If not the patient, name (print) of person signing this form:	Authority to sign this form on behalf of the patient (example: parent. legal guardian or health care proxy):

10/08/2009

NYU Langone
MEDICAL CENTER

FACULTY GROUP PRACTICE FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

1. **RELEASE OF INFORMATION:** I authorize NYU School of Medicine, my treating physicians and their respective designees, to use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes. _____**Initials**

2. **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to NYU School of Medicine. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. _____ **Initials**

3. **FINANCIAL LIABILITY:** I have been provided a copy of the NYU School of Medicine financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to NYU School of Medicine for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

   - My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at NYU School of Medicine and I have not obtained such an authorization or referral or I receive services in excess of such authorization or referral, and/or
   - My health plan determines that the services I receive at NYU School of Medicine are not medically necessary and/or not covered by my Insurance plan, and/or
   - My health plan coverage has lapsed or expired at the time I receive services at NYU School of Medicine, and/or
   - I have chosen not to use my health plan coverage. _____ **Initials**

4. **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

   Patient's Medicare Number _____ **Patient Signature** _____

5. **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at NYU School of Medicine; such as, anesthesia, interpretation of cardiac tests, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payor. _____ **Initials**

6. **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that I may incur a cancelation fee if I do not provide 24 hour notice of cancelation, or if I do not keep my appointment and have not canceled. _____ **Initials**

I have been provided the Faculty Group Practice Patient Financial Polices. I understand the information listed above which has been fully explained to me.

_____ _____
Patient Signature **Date**

_____ _____
Guarantor Signature **Date**

Form Revised: 10/25/2011

NYU Langone
MEDICAL CENTER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). In this notice I was advised of how health information about me may be used and disclosed by NYU Langone Medical Center, which includes both NYU Hospitals Center and NYU Faculty Group Practice and their staff. I was also told how I may obtain a copy of this information and correct errors in my health information.

_____

Print Name of Patient

_____

Signature of Patient (or Financially Responsible Party)

_____

Relationship to Patient

_____

Date

Revised: 10/25/11

NYU Langone
MEDICAL CENTER

Pharmacy Information

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions. In addition, when you run out of refills on your medication, the pharmacist can now electronically send renewal requests to this office for approval.
**Note: Controlled medications are not eligible for e-prescribing.

Please complete the information below if you are interested in e-prescribing.

Patient Name: _____

Preferred Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Alternate Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Laboratory Information

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to NYU laboratory.**

LabCorp	
Quest Labs	
NYU Lab	
Other External Location	

Please provide name of external location: _____