

Faculty Group Practice Patient Demographic Form

Patient Information	Name (Last, First, MI)				Today's Date		
	Street Address			City		State	Zip
	Home Phone () Preferred <input type="checkbox"/>		Work Phone () Preferred <input type="checkbox"/>		Cell Phone () Preferred <input type="checkbox"/>		
	SSN	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner <input type="checkbox"/> Other		
	Race	Ethnicity		Preferred Language	Email address		

Financially Responsible Party	Is patient responsible party/guarantor? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/>		Work Phone () Preferred <input type="checkbox"/>		Cell Phone () Preferred <input type="checkbox"/>		

Emergency Contact	Name			Relationship to Patient		
	Home Phone () Preferred <input type="checkbox"/>		Work Phone () Preferred <input type="checkbox"/>		Cell Phone () Preferred <input type="checkbox"/>	

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 <input type="checkbox"/>)			Physician Phone/Fax (if known) ()		
	Physician Address					

Insurance Information	Primary Insurance Company			Policy #		Group #	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)			
	Subscriber's Social Security #		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber		Work Phone ()
	Secondary Insurance Company			Policy #		Group #	
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)			
	Subscriber's Social Security #		Gender <input type="checkbox"/> Male <input type="checkbox"/> 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: ____/____/____	



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 cancellation fee if I do not provide 24 hour notice of cancellation, 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



**NYU Faculty Group Practice
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 Faculty Group Practice physicians and 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

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



SYSTEM REVIEW
NYU Cardiology Associates
530 1st Avenue, Suite 9U, New York, NY 10016
212-263-7751

Please / any that you now have or have had in the past 6 months.

<input type="checkbox"/> Headache
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Fatigue
<input type="checkbox"/> General weakness
<input type="checkbox"/> Appetite:
<input type="checkbox"/> Good
<input type="checkbox"/> Fair
<input type="checkbox"/> Poor
<input type="checkbox"/> Blurred vision or double vision
<input type="checkbox"/> Eye irritation or discharge
<input type="checkbox"/> Eye pain
<input type="checkbox"/> Discomfort looking at light
<input type="checkbox"/> Change in vision
<input type="checkbox"/> Do you wear eyeglasses/contact lenses?
No / Yes
<input type="checkbox"/> Date of last exam?
<input type="checkbox"/> Earaches or discharge from ears
<input type="checkbox"/> Ringing in ears or decreased hearing
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Nasal congestion
<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Strange, persistent odors or tastes (circle if yes)
<input type="checkbox"/> Loss of taste
<input type="checkbox"/> Hoarse voice
<input type="checkbox"/> Sore throat
<input type="checkbox"/> Sores in mouth
<input type="checkbox"/> Soreness or bleeding of gums on brushing
<input type="checkbox"/> Trouble swallowing
<input type="checkbox"/> Growth in neck or throat
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Angina
<input type="checkbox"/> Pain in arm(s)
<input type="checkbox"/> Change in color of fingers
<input type="checkbox"/> Palpitations or fluttering of heart
<input type="checkbox"/> Swelling of hands, feet or ankles AM PM
<input type="checkbox"/> Leg cramps:
<input type="checkbox"/> On walking
<input type="checkbox"/> At night
<input type="checkbox"/> Shortness of breath:
<input type="checkbox"/> Wakes you up
<input type="checkbox"/> On walking several blocks
<input type="checkbox"/> On walking one flight of stairs
<input type="checkbox"/> On lying down
<input type="checkbox"/> Coughing up blood
<input type="checkbox"/> Chronic or frequent cough:
<input type="checkbox"/> Dry
<input type="checkbox"/> With phlegm
<input type="checkbox"/> Wheezing

<input type="checkbox"/> Heartburn, indigestion, belching
<input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Avoidance of any foods
<input type="checkbox"/> Abdominal pain or cramps
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation
<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Difficulty or pain with urination
<input type="checkbox"/> Do you get up at night to urinate?
<input type="checkbox"/> How many times?
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Lose urine on coughing or sneezing
<input type="checkbox"/> Too frequent urination
<input type="checkbox"/> Vaginal or penile discharge
<input type="checkbox"/> Genital sores
<input type="checkbox"/> Problems with sex
<input type="checkbox"/> Backaches
<input type="checkbox"/> Joint pain or swelling
<input type="checkbox"/> Stiffness
<input type="checkbox"/> Dryness of skin
<input type="checkbox"/> Change in hair texture or skin texture
<input type="checkbox"/> Any skin rash
<input type="checkbox"/> New or change in moles or skin lesions
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Tingling or weakness of hands or feet
<input type="checkbox"/> Loss or change in sensation of hands or feet
<input type="checkbox"/> Trembling of arms, hands or legs
<input type="checkbox"/> Seizures
<input type="checkbox"/> Fainting? When?
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Inability to stand heat / cold (circle if yes)
<input type="checkbox"/> Excessive appetite
<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Enlarged glands
<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Other bleeding
<input type="checkbox"/> Hot flashes

List any other conditions for which you are treated and/or have been diagnosed:

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Patient Signature _____ Date _____

Reviewed by _____ Date _____