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1000 Northern Blvd. Suite 230
Great Neck, NY 11021

Primary Care Registration

First Name ______________________ MI ____ Last Name ______________________

Home Address / City / State / Zip ______________________________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Date of Birth ____________ Age ____ Marital Status: S ☐ M ☐ W ☐ D ☐ Gender: M ☐ F ☐

Preferred Language ____________________ Ethnicity: Non-Hispanic/Latino ☐ Hispanic/Latino ☐

Race (White, Asian, Black, Jamaican....etc) ______________________________

E-Mail ______________________ Social Security # ______________________

Is it ok to text you an appointment reminder? No ☐ Yes ☐ (If yes, cell phone carrier______________)

Is it ok to email you an appointment reminder? No ☐ Yes ☐

Emergency Contact Name ______________________ Phone Number ______________

Pharmacy ______________________ Phone Number ______________

Pharmacy Address / City / State / Zip ______________________________________

Primary Insurance ______________________ ID # or Certificate # ______________

Policy Holder (other than self) __________ Date of Birth ______ Relationship to Patient __________

How did you hear about HealthBridge? ______________________________

***Please list all treating doctors below with their phone numbers: (PCP, Cardiologist, etc...)**

Primary Care ______________________ Phone Number ______________

Cardiologist ______________________ Phone Number ______________

Other MD ______________________ Phone Number ______________

HEALTHBRIDGE

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Medical History

- ☐ Heart Disease
- ☐ Liver Disease
- ☐ Stroke or Seizure
- ☐ Thyroid Problems
- ☐ Cancer: ____________________
- ☐ Difficulty with Erections
- ☐ Anxiety Symptoms
- ☐ High Cholesterol
- ☐ Heart Murmurs
- ☐ Back or Neck Pains
- ☐ Stomach Ulcers/Heartburn
- ☐ Kidney Disease
- ☐ Depression
- ☐ Menstrual Problems
- ☐ Problems with Circulation
- ☐ Eating Disorders
- ☐ Sleeping Problems/Insomnia
- ☐ Diabetes
- ☐ Chest Pain or Pressure
- ☐ Arm Pain or Weakness
- ☐ High blood pressure
- ☐ Shortness of Breath
- ☐ Low Blood Sugar
- ☐ Snoring
- ☐ Loss of Sex Drive
- ☐ Asthma or Emphysema
- ☐ Abdominal Pains
- ☐ Irregular heart beat
- ☐ Dizziness/Fainting
- ☐ Leg Pain or weakness or cramps

Other Medical Problems Other Medical Problems ____

Other Medical Problems ____

Surgical Procedures ____

Surgical Procedures ____

Currently smoking? ☐ Yes ☐ No If previous smoker, what year did you quit? ____________________

If current smoker: _______ packs per day _______ number of years

On average, how many total drinks per week of beer, wine or other alcoholic beverages?
☐ less than 1 ☐ 1 - 5 ☐ 6 - 10 ☐ 11 - 15 ☐ 16 - 20 ☐ >20

Recreational drug use? ____

History of Drug abuse or Alcoholism? ____

Have you ever been the victim of any physical, sexual or psychological abuse? ☐ Yes ☐ No

If yes, please explain ____

Medication Allergies ____

Food Allergies ____

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Medical History

Medication/Supplements	Dose	Frequency	Medications/Supplements	Dose	Frequency

Women only: Are you pregnant / breast feeding? ☐ Yes ☐ No

Are you planning on getting pregnant? ☐ Yes ☐ No Last menstrual period? ______________________

Irregular menses? ☐ Yes ☐ No Difficulty getting pregnant? ☐ Yes ☐ No ☐ n/a

Excess hair growth? ☐ Yes ☐ No

Family and Genetic History (check all that apply)

Please help us to understand your family background, please list any diseases that run in your family.

____

____

____

When is the last time you have had: (Please check & fill in appropriate date)

☐ Complete Physical Exam ______________ ☐ Bone Densitometry Test ______________

☐ Exercise Stress Test ______________ ☐ Echocardiogram ______________

☐ Carotid Ultrasound ______________ ☐ Colonoscopy ______________

☐ Mammogram ______________ ☐ Pap Test ______________

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Sleep Quality

What time do you? Wake up ___________ Go to sleep ___________ How many hours do you sleep? ___________

Do you snore? ☐ Yes ☐ No Have you been told that you snore? ☐ Yes ☐ No

Do you choke or gag during sleep? ☐ Yes ☐ No

Has someone seen you stop breathing while sleeping? ☐ Yes ☐ No

Do you wake up tired in the AM? ☐ Yes ☐ No Do you wake during the night? ☐ Yes ☐ No

How often? ______________________________

For what reason? ______________________________

Does your spouse snore? ☐ Yes ☐ No Do you often feel the need to nap? ☐ Yes ☐ No

Do you easily fall asleep while in a movie theatre? ☐ Yes ☐ No

Do you fall asleep while a passenger in a car? ☐ Yes ☐ No

Exercise and Fitness Survey

How would you describe your daily activity level (based on your daily routine, not including scheduled exercise)

☐ Very Sedentary
☐ Sedentary to Moderate
☐ Moderate
☐ Moderate to Heavy
☐ Heavy

How often do you exercise?

Cardio (walking, running, biking,etc.)

☐ Rarely or never
☐ 1-2 times a week
☐ 3-4 times a week
☐ 5 or more times a week

Resistance (weights, lifting, etc.)

☐ Rarely or never
☐ 1-2 times a week
☐ 3-4 times a week
☐ 5 or more times a week

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How long have you been regularly exercising? ______________________________

Please describe your exercise routine: ______________________________

____

Have you ever worked with a personal trainer? ☐ Yes ☐ No

Do you find it hard to get motivated to work out? ☐ Yes ☐ No

Have you been restricted from exercise by a physician or other professional? ☐ Yes ☐ No

Why? ______________________________

Have you ever been treated by a chiropractor or physical therapist? ☐ Yes ☐ No

Why? ______________________________

Do you have any neck or back pains that restrict your exercise? ☐ Yes ☐ No

Describe: ______________________________

Do you get any symptoms on exertion that restrict your ability to exercise? ☐ Yes ☐ No

Describe? ______________________________

Do you have any leg or arm pains or weakness that restrict your exercise? ☐ Yes ☐ No

Describe? ______________________________

I hereby affirm that I have answered these questions as completely and accurately as possible. I realize that failure to divulge any pertinent medical information may adversely affect my results in this program, and may result in injury or adverse outcomes.

Signature: ______________________________ Date: ______________

Print Name: ______________________________

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Name: ____

**I hereby authorize payment of all authorized Medicare or other insurance medical benefits be made either to me or on my behalf to North Shore Primary Care Medical Associates PC (hereinafter "NSPC"), the office of David G. Edelson, MD; William M. Klein, MD; Susan E. Mirkinson, MD; Deborah S. Blenner, MD for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

** I acknowledge my responsibility to pay for all medical services rendered by this doctor regardless of any insurance coverage.

Signature: ____ Date: ________________

** I understand that NSPC is not responsible for any balances due from Laboratories resulting from my healthcare coverage.

Signature: ____ Date: ________________

Please initial all that apply:

• I give NSPC authorization to leave "normal" test results on my answering machine or voicemail at home. _________

• I give NSPC authorization to leave "normal" test results on my answering machine or voicemail at work. _________

• I give NSPC authorization to e-mail me "normal" test results. (I understand that this is encrypted and requires password to open) _________

• I give NSPC authorization to give my ____________________ pertinent medical information, normal test results or medication change / information for myself. _________

• I give NSPC authorization to give my ____________________ "abnormal" test results for myself. _________

• I prefer my primary number to be: ____ Home ____ Office ____ Cell

• I authorize NSPC to ☐ e-mail ☐ text me appointment confirmations and yearly exam reminders. _________

• I DO NOT wish to receive any e-mails regarding updates, events or news related to information pertaining to HealthBridge / NSPC. _________

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Acknowledgement of Receipt of Notice of Privacy Practice

Name of Patient: ____

Signature of Patient: ______________________________ Date: _______________

Signature of Patient Representative (required if the patient is a minor or an adult who is unable to sign this form).

Signature of Patient Representative: ______________________________________

Relationship of Patient Representative to Patient ______________________________

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

Background: In 1996, Congress recognized the need for national patient privacy standards and, as part of the Health Insurance Portability and Accountability Act, abbreviated as HIPAA, ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for bank accounts, credit cards and even video rentals.

- By the law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows, also, for a prescription to be called into your pharmacy and for scheduling of surgery in a hospital.
- Additionally, none is needed in the course of carrying out health care operations such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or use of sign-in sheets.
- However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent.
- Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer or for use in marketing a product to you.
- Medical information about you may be released for research and public health uses, as long as you are not individually identified.
- You are guaranteed access to review your medical record, and you may amend the record if you believe it to be incomplete for inaccuracy.
- You have the right to review when and to whom your information was released.
- You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.
- Portions of this notice may be modified, as long as you are notified.
- Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you, to this office or to the Secretary of Health.
- The law requires that you acknowledge receipt of this notice.