



office: (516) 627 4433
fax: (516) 627 0552
1000 Northern Blvd. Suite 230
Great Neck, NY 11021

Weight Management 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 _____

Medical History

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

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)

- | | |
|---|---|
| <input type="checkbox"/> Complete Physical Exam _____ | <input type="checkbox"/> Bone Densitometry Test _____ |
| <input type="checkbox"/> Exercise Stress Test _____ | <input type="checkbox"/> Echocardiogram _____ |
| <input type="checkbox"/> Carotid Ultrasound _____ | <input type="checkbox"/> Colonoscopy _____ |
| <input type="checkbox"/> Mammogram _____ | <input type="checkbox"/> Pap Test _____ |

Weight History (Estimate your average weight range for the time frames indicated)

15 - 20 yrs. old _____ 41 - 50 yrs. old _____
21 - 30 yrs. old _____ Over 50 yrs. old _____
31 - 40 yrs. old _____

Diet and Nutrition History (Mark your answers)

How many meals do you eat in a typical day? 1 2 3 4 5 5+

How many snacks do you eat in a typical day? 1 2 3 4 5 5+

Do you skip meals? If yes, which ones? Yes No Breakfast Lunch Dinner

Do you plan your meals? Yes No

Have you ever been diagnosed with an eating disorder? Yes No

Have you ever had bulimia or anorexia? Yes No

What are your favorite foods or type of food? _____

Are there any foods you will not eat? _____

Are there foods you can't stop eating once you start? _____

How many times a week do you eat out? (Include take out) Breakfast Lunch Dinner

Are you distracted during meal times? Yes No

Do you eat in response to ANGER? Yes No BOREDOM? Yes No STRESS? Yes No

Do you drink sodas, juices, teas, or other beverages?

Regular Yes No Type and how much? _____

Diet Yes No Type and how much? _____

How many 8 oz. glasses of water to you drink per day? _____

How many times a day do you move your bowels? _____



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Please rate the following:	1 (Low)	2	3 (Medium)	4	5 High
Will power:	1	2	3	4	5
Self Esteem:	1	2	3	4	5
Binging:	1	2	3	4	5
Food cravings:	1	2	3	4	5
Sugar cravings:	1	2	3	4	5
Salt cravings:	1	2	3	4	5
Anxiety symptoms:	1	2	3	4	5
Commitment to losing weight:	1	2	3	4	5

Previous Diet Experience: (Please skip if not applicable)

How many times have you lost weight and gained it back? _____

Have you tried and of these diets?	Successful from the beginning?		Successful long term?	
	Yes	No	Yes	No
My own diet:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Watchers:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jenny Craig:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutri System:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atkins or Low carb diet:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Zone Diet:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ornish Diet or Vegetarian diet:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
South Beach Diet:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liquid diet (Slim Fast, Juices..etc):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optifast or Medifast:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTC diet pills (Ephedra, ALLI..etc):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Precription diet pills:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Daily Routines:

What time do you eat? Breakfast _____ Lunch _____ Dinner _____

Describe a typical breakfast: _____

Describe a typical lunch: _____

Describe a typical dinner: _____



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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 Moderate Heavy
 Sedentary to Moderate Moderate to Heavy

How often do you exercise?

Cardio (walking, running, biking, etc.)

Resistance (weights, lifting, etc.)

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

Are there any exercises you've done in the past that you wish you could do now? _____

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.