NEW PATIENT
PRIOR MEDICAL INFORMATION

NAME ____________________

DOB ____________________

Have you had any recent blood work? YES ☐ NO ☐

If YES:
Date __________ Lab ____________________

Have you had any recent testing done? YES ☐ NO ☐

If YES:
Date __________ Lab ____________________

Have you been hospitalized recently? YES ☐ NO ☐

If YES:
Date __________ Lab ____________________
Reason ____________________
____

Have you requested your records from your primary/specialist to be sent to us? YES ☐ NO ☐

Do you have your insurance referral? (If necessary) YES ☐ NO ☐

Welcome to our office and thank you for selecting Grand Street Medical Associates. We will be happy to provide you the best possible healthcare. To help us meet all of your needs, please fill out the form below completely. If you have any questions, or need assistance, please ask us. We will be happy to help.

Name Mr ☐ Mrs ☐ Ms ☐			
Marital Status S ☐ M ☐ W ☐ D ☐ Sep ☐	Date of Birth	Age	M ☐ F ☐
Street Address	Phone (H)	Phone (O)	
City/State/ZIP	Personal Physician		
Occupation/Employer	Spouses Occupation/Employer		
Spouses Name	If UNDER 18, Parent/Guardian		
Emergency Contact (Other than Spouse)	Contact Address	Contact Phone	
Social Security Number	Referred by		

INSURANCE AND BILLING INFORMATION

Insurance Company (Primary)	Address	Effective Date
Subscriber's Name	Identification Number	Group Number
Subscriber's Social Security Number	Date of Birth	Benefit Code
Insurance Company (Secondary)	Address	Effective Date
Subscriber's Name	Identification Number	Group Number
Subscriber's Social Security Number	Date of Birth	Benefit Code

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. ________________ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. THIS OFFICE IS NOT RESPONSIBLE FOR ANY DISSEMINATION OR DISCLOSURE OF YOUR CONFIDENTIAL MEDICAL INFORMATION ONCE WE PROVIDE SUCH INFORMATION, AT YOUR REQUEST TO YOUR HEALTH INSURER OR EMPLOYER.

Your Signature: ________________________________ Date: __________________

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical to Dr. ______________________ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Your Signature: ________________________________ Date: __________________

MEDICARE/MEDICAID

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ______________ for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

Patient's Signature: _____________________________ Date: __________________

Physician's Signature: ___________________________ Date: __________________

PAYMENT IS REQUESTED AT THE TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

HISTORY & PHYSICAL

NAME ______________________
SS # ______________________
Date ______________________
Address ______________________
Occupation ______________________
Phone (Home) ______________________
Phone (Work) ______________________
Date of Birth ______________________
Chief Complaint & History ______________________
____
____
____
Drug Allergies ______________________
____
Current Medications ______________________
____
Hospitalization or Surgery ______________________
____
Past Medical History ______________________
____
Menstrual History ______________________
Last Pap Smear ______________________
Last Mammogram ______________________
Other ______________________

Family History	**Father**	**Mother**	**Siblings**
Heart Disease			
High Blood Pressure			
Stroke			
Cancer			
Diabetes			
Epilepsy/Convulsions			
Bleeding Disorder			
Mental Illness			
Other			

Personal History

Smoking YES ☐ NO ☐
Packs Daily ______________
How Long ______________
When Stopped ______________
Alcohol ______________
Exercise ______________
Other ______________
Sleep ______________
Difficulty falling asleep ______________
Continuing Disturbances ______________
Snoring ______________
Early Morning Awakening ______________

HISTORY & PHYSICAL
Review of Symptoms

Constitutional Symptoms			Integumentary			Musculoskeletal		
Fever	Y ☐	N ☐	Skin Rash	Y ☐	N ☐	Join Pain	Y ☐	N ☐
Chills	Y ☐	N ☐	Boils	Y ☐	N ☐	Neck Pain	Y ☐	N ☐
Headache	Y ☐	N ☐	Persistent Itch	Y ☐	N ☐	Back Pain	Y ☐	N ☐
Weight Gain/Loss	Y ☐	N ☐	Other			Other		
Other								

Eyes			Allergic/Immunologic			Ear/Nose/Throat/Mouth		
Blurred Vision	Y ☐	N ☐	Hay Fever	Y ☐	N ☐	Ear Infection	Y ☐	N ☐
Double Vision	Y ☐	N ☐	Drug Allergies	Y ☐	N ☐	Sore Throat	Y ☐	N ☐
Pain	Y ☐	N ☐	Other			Sinus Problems	Y ☐	N ☐
Other						Other		

Neurological			Genitourinary			Endocrine		
Tremors	Y ☐	N ☐	Urine Retention	Y ☐	N ☐	Excessive Thirst	Y ☐	N ☐
Dizzy Spells	Y ☐	N ☐	Pain Urination	Y ☐	N ☐	Too Hot/Cold	Y ☐	N ☐
Numbness/Tingling	Y ☐	N ☐	Frequent Urination	Y ☐	N ☐	Tired/Sluggish	Y ☐	N ☐
Other			Blood in Urine	Y ☐	N ☐	Other		
			Other					

Respiratory			Gastrointestinal			Hematologic/Lymphatic		
Wheezing	Y ☐	N ☐	Abdominal Pain	Y ☐	N ☐	Swollen Glands	Y ☐	N ☐
Frequent Cough	Y ☐	N ☐	Nausea/Vomiting	Y ☐	N ☐	Blood Clotting Problem	Y ☐	N ☐
Shortness of Breath	Y ☐	N ☐	Indigestion/Heartburn	Y ☐	N ☐	Other		
Other			Other					

Cardiovascular			Psychologic			Sexual Dysfunction	Y ☐	N ☐
Chest Pain	Y ☐	N ☐	Are you satisfied with your life?			Other		
Varicose Veins	Y ☐	N ☐		Y ☐	N ☐			
High Blood Pressure	Y ☐	N ☐	Do you feel severely depressed?					
Other				Y ☐	N ☐			
			Have you considered suicide?					
				Y ☐	N ☐			
			Other					

IN ACCORDANCE WITH THE PRIVACY LAWS DICTATED BY HIPAA, WE CAN NO LONGER LEAVE MESSAGES ON YOUR PHONE OR WITH ANOTHER PERSON WITHOUT YOUR WRITTEN CONSENT. IF YOU WOULD LIKE US TO LEAVE A MESSAGE ON YOUR ANSWERING MACHINE OR SPEAK WITH A PERSON OF YOUR CHOICE, PLEASE FILL OUT THIS FORM AND SIGN BELOW

THANK YOU
GRAND STREET MEDICAL ASSOCIATES

[ ] I give my permission for the staff of Grand Street Medical Associates to call and/or leave a message at the following phone number or speak with the following individuals concerning my care:

Spouse/Significant Other ____

Child ____

Other ____

This permission is granted from the period of: Date: ______________ to Date: _____________

Patient's Name (Please Print): ____

Date of Birth: ___________________________

Patient's Signature: _________________________________ Date Signed: ________________

27 Grand Street Kingston, NY 12401 www.GSMAdoc.com
Phone: 845-334-9951 Fax: 845-338-7092

CONSENT TO TREAT, USE AND DISCLOSE PROTECTED INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

1. **Patient Consent to Treat**
   I, the undersigned patient, consent to treatment by the provider.

2. **Patient Consent for use and Disclosure of Protected Health Information ("PHI")**
   I, the undersigned patient, give my consent to the provider and his or her agents to use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care operations. These individuals and entities can release, use, disclose my PHI to other physician, nursing staff, nurse practitioners, physician assistants, students in each of the above disciplines, and other such entities or persons as are deemed related to treatment, payment, and health care operations, as determined in the sole discretion of the provider and his or her respective agents.

3. **Permission to Release Medical Record to Providers**
   If another provider who is involved with treatment, payment or health care operations relating to me requests my medical records, I consent to the release of my entire medical record maintained by the provider to those other providers.

4. **Permission to Release Billing Information Over the Telephone**
   I agree, as part of this consent for payment operations, that the provider, its group, and their billing personnel, billing agents, or management company can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides the correct social security information or health plan number.

5. **Permission to Leave Voice Mail Messages**
   I agree that the provider or its agents or representatives may call and leave a voice mail at my home or other number I provide them regarding medical appointments, billing or payment issues or other information related to treatment, payment, or health care operations.

6. **Permission to Discuss Protected health Information with Third Parties**
   I agree that the provider may discuss my PHI with any person that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to the person. I also agree the provider may discuss my PHI with any person that identifies him or herself as active in my mental physical emotional or spiritual care, including but not limited to family, friends, clergy, and patient advocates. I also agree that the provider and his or her agents may disclose my PHI to employers who arrange any pay, directly, or indirectly for my medical treatment.

7. **Permission to Discuss Protected Health Information Regarding Minors**
   I agree that the provider and his or her agent may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.

8. **Permission to Discuss Protected Health Information with Public Agencies**
   I agree the provider and his or her agents may upon request by the following entities, disclose my PHI to public health agencies, law enforcement, and the FDA.

9. **Acknowledgement of Receipt of Notice of Privacy Practices**
   I acknowledge that I have received from this provider a copy of separate document, entitled, 'notice of privacy practices' which sets forth this provider's privacy practices and my rights regarding privacy of my PHI.

Patient's Name (PLEASE PRINT): ____

Patient's Signature: ______________________________ Date Signed: ______________________