PLATTSBURGH MEDICAL CARE

675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

New Patient Information Sheet

Patient's Full Legal Name: _____
(First) (Middle) (Last)

Social Security Number: _____ Sex: ___Male ___Female

Date of Birth: _____ Age: _____

Marital Status: (Circle One) Single Married Widowed Divorced Separated

PATIENT ADDRESS INFORMATION

Address:_____
Street City State Zip Code

E-Mail Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Primary Care Physician: _____

We are now required to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose Refused to Report/Unreported.

(Please check ONE in EACH CATEGORY that applies)

RACE	ETHNICITY	PREFERRED LANGUAGE
≤ White	≤ Hispanic or Latino	≤ English
≤ Black or African American	≤ Not Hispanic or Latino	≤ Spanish
≤ Native Hawaiian	≤ Refused to Report/Unreported	≤ French
≤ Asian	≤ Undefined	≤ Hindi
≤ Other Pacific Islander		≤ Vietnamese
≤ American Indian or Alaskan Native		≤ Refused to Report/Unreported
≤ Undefined		≤ Other: _____
≤ Refused to Report/Unreported		

IF PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE PARENT/GUARDIAN/GUARANTOR SECTION BELOW:

Parent/Guardian/Guarantor Name: _____

Address (If different from above):_____
Street City State Zip Code

Home Phone: (_____)_____ Cell: (_____)_____

Relationship to Patient: _____

Date of Birth: _____/_____/_____ Sex: _____M _____F

PLATTSBURGH MEDICAL CARE

675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

Notice of Privacy Practices Information:

****Please note that if individuals other than you have access to the contents of any of the addresses listed below, those individuals could also have access to any information we send to you at that address. Plattsburgh Medical Care will not be responsible if such individuals access information that is sent to the information you provide. ****

1. Please list the family members and/or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

- Name: _____ Phone #: (_____)_____

  Relationship: _____

- Name: _____ Phone #: (_____)_____

  Relationship: _____

- Name: _____ Phone #: (_____)_____

  Relationship: _____

2. Please list the telephone number(s) where you want to receive calls about your appointments, lab and x-ray results, or other health information:

- Primary: (_____)_____
- Secondary: (_____)_____

3. Can confidential messages (i.e. appointment information, results, etc.) be left on your answering machine?

____ Yes ____ No

4. We now offer an online patient portal through our website (pmedcare.com). This allows you to have real-time access to your medications, labs, and upcoming appointments. In addition, you will also be able to request appointments and medication refills, and message your provider. Would you like access to this service? If yes, please see the receptionist for your activation code and instructions. (Note: If you choose to decline access to the portal today, you can obtain access at any time in the future.)

____ Yes ____ No

Please note that while we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.

PLATTSBURGH MEDICAL CARE
675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

PLATTSBURGH MEDICAL CARE

675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

The undersigned makes the following acknowledgments and agreements regarding treatment to be provided to the patient whose name appears above:

1 – **Consent to treatment**: I consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

2 – **Release of medical information**: I authorize the release of any medical or other information from this provider and other providers necessary to process a health insurance claim or to provide treatment.

3 – **Assignment of benefits**: I authorize payment of medical benefits to Plattsburgh Medical Care, LLC.

I certify that the information given at the time of registration is correct. I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise discussed before I am seen. I understand I am financially responsible to Plattsburgh Medical Care for charges not covered by insurance.

EMERGENCY CONTACT INFORMATION

Emergency Contact 1: _____

Relationship: _____

Home Phone: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Emergency Contact 2: _____

Relationship: _____

Home Phone: (_____)_____ Work: (_____)_____ Cell: (_____)_____

PLATTSBURGH MEDICAL CARE

675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

Group Insurance Information:

PLEASE HAVE YOUR INSURANCE CARD(s) READY TO BE COPIED

Primary Insurance:_____

Member ID: _____

Policyholder Name:_____

Policyholder Date of Birth:_____/_____/_____

Group #:_____

Patient's relation to policyholder: (Circle One) Self Wife Husband Child Parent Other

Secondary Insurance:_____

Member ID: _____

Policyholder Name:_____

Policyholder Date of Birth:_____/_____/_____

Group #:_____

Patient's relation to policyholder: (Circle One) Self Wife Husband Child Parent Other

Employment Information:

Employer Name: _____

Occupation:_____

Employer Address: _____
Street City State Zip Code

Work Phone: (_____) _____ ext. _____

Pharmacy Information:

Preferred Pharmacy: _____
(If mail order, please indicate a local pharmacy you would use in the case of an emergency below)

Secondary Pharmacy: _____

CONSENT FOR RELEASE OF MEDICAL RECORDS

PLATTSBURGH MEDICAL CARE

675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

You may encounter fees for release of medical records

FOR: Patient's Name: _____
Patient's Address: _____
Patient's Birth Date: _____
Patient's Social Security Number (*last 4 digits only*): XXX-XX-_____

RECORDS REQUESTED FROM:

Practice/Physician Name: _____
Physician Address: _____
Physician Phone #: _____ Fax #: _____

SEND RECORDS TO:
(Faxing is Preferred)

Please Check One of the Following:
_____ Send all of my records.
_____ Send only the following records:_____
_____ Send records from (date(s)): _____

PURPOSE/USE OF THE REQUESTED INFORMATION:

Please Check One of the Following:
_____ Insurance Purposes
_____ Transfer of Care (This means you will no longer see the provider that the records are requested from)
_____ Other:_____

PLEASE NOTE: *This authorization includes consent for release of alcohol, drug, psychiatric information, and any information relating to HIV testing, AIDS, and AIDS-Related Syndrome, which may be included in my records. I agree that a copy of this release or a fax of this release shall be as valid as the original. Please send copies of all requested information as soon as possible to the address listed above.*

By signing below, I do hereby consent and authorize you to release copies of my medical records.

Patient's Signature: _____ Date: _____

Witness:_____ Date: _____

Adult (18+ years of age) Medical History Form

PLATTSBURGH MEDICAL CARE

675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

Please complete all information on this form to the best of your knowledge.
If none in a particular section, write N/A or none.

Patient Name: _____ Date of Birth: _____

Past Medical History: (Please check all items that apply)

☐ Alcohol abuse	☐ Cancer: _____	☐ Heart Disease	☐ Liver Disease	☐ Psychiatric Disorder
☐ Alzheimer's	☐ Chronic Pain	☐ Heart Murmur	☐ Lung Disease	☐ Seizure Disorder
☐ Anemia	☐ COPD	☐ Heart Surgery	☐ Memory Problem	☐ Skin Problem
☐ Arthritis	☐ Depression	☐ Heartburn	☐ Migraines	☐ STD: _____
☐ Asthma	☐ Diabetes	☐ High Cholesterol	☐ Multiple Sclerosis	☐ Stroke
☐ Blood Clot	☐ Drug Abuse	☐ Hypertension	☐ Muscle Problem	☐ Thyroid Disease
☐ Blood Disease	☐ Ear Problem	☐ Joint Problems	☐ Parkinson's Disease	☐ Use of Tobacco
☐ Bowel Disease	☐ Eye Problem	☐ Kidney Disease	☐ Peripheral Vascular Disease	☐ Other:_____ _____

Allergies: (List allergen name and the type of reaction, write N/A if none)

Medication(s):_____ Reaction: _____

Medication(s):_____ Reaction: _____

Medication(s):_____ Reaction: _____

Medication(s):_____ Reaction: _____

Food/Insects/Other: _____ Reaction: _____

Food/Insects/Other: _____ Reaction: _____

Immunizations: (List month/year of last immunization)

Flu:	Hepatitis B:	Shingles:
Gardasil:	Meningitis:	Tetanus:
Hepatitis A:	Pneumovax:	Other:

PLATTSBURGH MEDICAL CARE

675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

Surgeries: (Check all surgeries that you have had and circle corresponding side Right or Left.)

☐ Appendectomy (Appendix)	☐ Cataract Removal R L	☐ Inguinal Hernia Repair R L	☐ Tonsillectomy (Tonsils)
☐ Breast Augmentation	☐ Cholecystectomy (Gall Bladder)	☐ Laminectomy (Cervical)	☐ Umbilical Hernia Repair
☐ Breast Biopsy R L	☐ Coronary Artery Bypass	☐ Laminectomy (Lumbar)	☐ Vasectomy
☐ Breast Lumpectomy ☐ R L	☐ Hysterectomy (Partial)	☐ Prostatectomy (Prostate)	☐ Other: _____
☐ Breast Mastectomy R L	☐ Hysterectomy (Total)	☐ Thyroidectomy (Thyroid)	☐ Other: _____

Diagnostic Studies: (List month/year of last diagnostic study and reason for the study)

X-ray:	Stress Test:
CT Scan:	Ultrasound:
MRI:	Other:

Health Maintenance: (List month/year of last screening/evaluation and where it was done)

Bone Density:	Colonoscopy:	Eye Exam:
Last Pap:	Cholesterol:	Hearing Exam:
Mammogram:	PSA:	Diabetic Foot Exam:

Current Medications: (List the **name, dose, and frequency** of each medication you take.)
Please also include ALL supplements and over the counter medicines.

Name of Medication	Dose (i.e. mg)	Frequency (i.e. once daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLATTSBURGH MEDICAL CARE

675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

_____ _____ _____

_____ _____ _____

Family History: Does anyone in your family (i.e. mother, father, grandparents, brothers, sisters, aunts, uncles, or children) have any of the following? If yes, who? If family history is unknown, please check unknown.

___ Yes ___ No; Cancer If yes, who?_____
___ Yes ___ No; Diabetes If yes, who? _____
___ Yes ___ No; Drinking Problems If yes, who? _____
___ Yes ___ No; Drug Problems If yes, who?_____
___ Yes ___ No; Heart Problems If yes, who?_____
___ Yes ___ No; High Blood Pressure If yes, who?_____
___ Yes ___ No; Learning Problems If yes, who?_____
___ Yes ___ No; Lung Problems (asthma) If yes, who?_____
___ Yes ___ No; Mental Illness (depression) If yes, who?_____

- **Unknown/Adopted**

Social History:

Substance Abuse:

Cigarette Smoking? ____ Yes ____ No Packs Per Day: _____ How Long? _____
Former Smoker? ____ Yes ____ No What year did you quit? _____
Chewing Tobacco? ____ Yes ____ No **Smoke Exposure**? ____ Yes ____ No
Any Alcohol Use? ____ Yes ____ No If yes, what? Beer Wine Liquor How Often?_____
Any Drug Use? ____ Yes ____ No What type of drug?_____
Any Caffeine Use? ____ Yes ____ No If yes, what? Coffee/Tea Soda Energy Drinks _____/day

Exercise/Diet:

Exercise: ____ Yes ____ No If yes: _____x/week Type: _____

Diet: Regular Diabetic Low Fat Low Salt Other:
_____

Hobbies:_____

Communication Needs:

Do you have hearing loss, wear hearing aids, or have deafness? ____ Yes ____ No;
If yes, describe:_____

Do you have visual loss, wear glasses or contacts, or have blindness? ____ Yes ____ No;
If yes, describe: _____

Legal Guardian/Health Care Proxy:

Do you have a legal guardian or Healthcare Power of Attorney? ____ Yes ____ No;
If yes, whom?_____

PLATTSBURGH MEDICAL CARE

675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210

Do you have a Living Will or Advanced Directives? ____ Yes ____ No; If yes, provide a copy to the office.

Do you have a DNR (Do Not Resuscitate) order? ____ Yes ____ No; If yes, provide a copy to the office.

Current Symptoms: (Check all symptoms that you currently have)

General:
__ Chills
__ Fatigue
__ Fever
__ Night Sweats
__ Sleep Difficulties
__ Weight Gain
__ Weight Loss

Skin:
__ Bruising
__ Changes in Moles
__ Dryness
__ Hair loss
__ Itching/Rash
__ New lesions
__ Scalp problems
__ Yellowing of skin

Eye/Ear/Nose/Throat:
__ Earache
__ Gums bleeding
__ Hearing decreased
__ Nose bleeds
__ Ringing in ears
__ Runny nose
__ Sinus pain
__ Sore throat
__ Throat hoarseness
__ Visual disturbances
__ Vomiting blood

Neck:
__ Neck Mass
__ Neck Pain
__ Swollen Glands

Respiratory:
__ Cough
__ Coughing up Blood
__ Shortness of Breath
__ Sputum Production
__ Wheezing

Breast:
__ Breast Pain
__ Breast Lump
__ Nipple Discharge

Cardiovascular:
__ Chest Pain
__ Chest Pressure
__ Palpitations

Gastrointestinal:
__ Abdominal Pain
__ Black, Tarry Stool
__ Constipation
__ Diarrhea
__ Difficulty Swallowing
__ Nausea
__ Rectal Bleeding
__ Vomiting

Female Genitourinary:
__ Pelvic Pain
__ Urinary Complaints
__ Vaginal Bleeding Problem
__ Vaginal Discharge

Male Genitourinary:
__ Blood in Urine
__ Impotence
__ Penile Discharge
__ Urination Difficulty

Musculoskeletal:
__ Joint Pain
__ Muscle Pain Swings
__ Muscle Weakness
__ Swelling of Area: _____

Neurological:
__ Dizziness
__ Fainting Spells
__ Headaches
__ Memory Problems
__ Numbness
__ Seizures
__ Tremors
__ Weakness

Endocrine:
__ Appetite Changes
__ Excessive Thirst
__ Hot Flashes

Hematology:
__ Anemia
__ Blood Clot in Legs
__ Blood Clot in Lungs

Psychiatric:
__ Anxiety
__ Depression
__ Mood
__ Change in Sleep Pattern

How would you rate your overall health? ≤ Good ≤ Fair ≤ Poor

Do you see any specialists? ____ Yes ____ No

If yes, please list doctor's name and specialty.

_____

_____

Do you have any specific questions that you want your doctor to address? ____ Yes ____ No

PLATTSBURGH MEDICAL CARE
675 Route 3 • Plattsburgh, NY 12901 • P: 518-566-0672 • F: 518-324-2210