

Please check and/or fill in the information below and make changes as necessary:

Patient information Name: _____ Address: _____ Contact Numbers: Home: _____ Work: _____ Cell: _____ Date of Birth: _____	Insurance Information: ID # _____ Plan Name: _____ Address: _____ Insured Party (if not self): Name: _____ Date of Birth: _____ Relation to Patient: _____
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Please provide the following additional information: Do you have a secondary insurance: YES No

e-mail address: _____ SS#: _____

Pharmacy Name: _____ Pharmacy Address: _____

Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

HIPPA/Payment Agreement Permission to discuss your health information with others (e.g. spouse, parents, children, significant others):

I do not want my information discussed with anyone other than myself _____ (Please Initial)

You may speak with: _____

By signing this form, I consent to the use and disclosure of any and all protected health information about me (or this above indicated under-aged minor) for treatment, payment, or health care operations. This authorization is in effect now and will remain in effective for 2 years from the date of my signature below. I have the right to revoke this consent at any time with a written, dated and signed notification. However, such revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I agree to the use of a Patient Portal and I understand that this is NOT the primary form of communication with the office. I should call the office for any questions and concerns.

Test Results I understand and agree that all lab, diagnostic and bone density results will be reviewed in person at a follow-up visit with a provider.

Insurance and Billing Information

_____ **Pt initials**

In order to be seen today we must have a copy of your current insurance card and drivers license/photo ID in our computer system. If you do not have your card with you, you may settle your account in full today and our office will provide you with a receipt to file with your insurance. I understand that by signing below I am responsible for payment of any and all fees for services rendered. I am responsible for understanding the terms of my insurance policy including deductibles, co-pays, required authorizations, network providers and all out-of-pocket expenses. I authorize payment to Dr. Kathy Santoriello MD PA and agree that I am responsible for all unpaid balances and non-covered services. I also agree to a \$25 fee for cancelling a visit without 24-hour advanced notice.

Authorization for Release of Medical Record

I request that Dr. Kathy Santoriello MD PA provide medical care as deemed appropriate to me or this above indicated under-aged minor. I authorize Dr. Kathy Santoriello MD PA to release requested information to my insurance company for the purposes of billing and collection. I further authorize Dr. Kathy Santoriello MD PA and staff access to and or a copy of any and all of my medical records for the purposes of medical treatment and continuity of care from any medical provider or facility. I understand I have the right to a copy of this release and the "Notice of Privacy Practices".

PATIENT SIGNATURE: _____ DATE: _____

If under 18, Responsible Party: _____ Relationship to Pt: _____ DATE: _____

New Patient Check In Form

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Reason for Visit: Yearly Exam Other: _____

Referring Doctor: _____

Please list what you take or use! (Medications/Vitamins/Supplements/Creams/Anything over-the-counter):

Medications (Name and Dose)

Vitamins/Over-The-Counter Supplements/Creams

Allergies: NO YES (please list) _____

REVIEW OF SYMPTOMS: Please Circle any of the following conditions you have had or now have.

Eye & Vision: loss of hearing; buzzing; infections

Nose & Throat: hoarseness; difficulty swallowing; nosebleed; frequent sneezing; thyroid disorder

Respiratory: shortness of breath; wheezing; cough; asthma; sleep apnea; Tuberculosis

Cardiovascular: chest pain; abnormal heartbeat;
swelling of ankles or feet; varicose veins; heart attack; stroke; leg clots; pacemaker, atrial fibrillation

Gastrointestinal: abnormal pain; nausea or vomiting;
loss of appetite; diarrhea; blood in stool; constipation;
weight loss; heartburn; hepatitis, fatty liver, colitis.

Urinary: urinary incontinence, urinate when coughing, blood in urine, increased frequency; painful urination, wearing pads, nightly urination.

Integumentary: itching skin, rashes, sores not healing, herpes, cold sores, shingles, skin cancers.

Musculoskeletal: joint pain or swelling, difficulty walking, neck or back pain, use of cane/walker/wheelchair.

Neurologic: headaches, dizziness, seizures, numbness or tingling, lapse of memory, blackouts

Blood: diabetes, cholesterol, high blood pressure, clotting disorder, other blood disorder.

Psychological: depression, excessive worry, severe tension, hopelessness, use of medications.

Diet: use of phenphen, use of herbs, eating disorder, swallowing trouble.

Sexual Dissatisfactory: discomfort, pain, lack of sensation, lack of interest, poor arousal.

For MA use only: Vital Signs

HT: _____ WT: _____ BP: _____ Temp: _____ RR: _____ Pulse: _____
LMP: _____ SBE: YES NO

OB/GYN History:

How many total pregnancies have you had? _____

How many preterm births (prior to 37 weeks gestation)? _____

How many abortions? _____

How many living children? _____

Around what age did you start your menstrual cycles? _____

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you currently on birth control? Any complications with taking birth control?(Ex: dizziness, weight gain, nausea)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you been vaccinated for the HPV virus?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If not, would you like information on the vaccine?

Medical History: If yes, please state issue, date of diagnosis and treatment.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have a primary care physician? If yes please state name of physician
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any history with cancer (Ex: breast, cervical, skin)? Please state type and date of diagnosis?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any breast issues?(biopsies, abnormal mammograms, fibrocystic breast, breast pain)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any cosmetic surgery?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any gynecological issues? (Ex: abnormal pap's, viruses, dryness, libido, procedures)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any cardiology issues? (Ex: murmur, cholesterol, strokes, pacemaker)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any pulmonary issues? (Asthma, Sleep apnea, tuberculosis)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any gastrointestinal issues? (GERD, procedures, constipation, Hepatitis)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any Urinary issues? (Leaking, prolapsed, procedures, kidney stones)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any endocrine issues? (Thyroid, metabolism, diabetes, procedures)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any hematology issues? (Anemia, sickle cell hyper coagulation, procedures)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any musculoskeletal issues? (Arthritis osteoporosis, knee /back, procedures)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any neurological issues? (ALS, Parkinson, neuropathy, procedures)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any psychiatry issues? (Bipolar, anxiety, depression, procedures)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any rheumatology issues? (Fibromyalgia, RH arthritis, Lupus, procedures)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any skin issues? (Acne, eczema, psoriasis, procedures)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any trauma/toxins issues? (Burns, drug overdose, motor vehicle accident, fractures, procedures)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any other medical history?

Family History:

- Yes No Do you have any family history of breast/ovarian/uterus cancer?
 Yes No Are you adopted or have unknown family history?

Mother: Living Deceased Does she have any major medical diagnosis? (heart disease, cancer, diabetes, thyroid, breast, blood pressure, cholesterol) _____

Father: Living Deceased Does he have any major medical diagnosis? (Heart disease, cancer, diabetes, thyroid, blood pressure, cholesterol) _____

Social History: Single Married Divorced Widowed Remarried Lesbian

Please answer the following questions for the Quality Measures Data based. Thank You.

Have you ever had a bone density test to **screen for osteoporosis**? YES NO

Have you had a **mammogram** to screen for breast cancer in the past 27 months? YES NO

Have you had a **colonoscopy** to screen for colorectal cancer within the past 9 years? YES NO

Have you ever received a **pneumococcal vaccine**? YES NO

Have you received the **Flu vaccine** between Oct 1 and March 31 or previous year? YES NO

Are you currently a tobacco user? YES NO

If YES, How many packs a day for how long? _____

Yes No Are you ready to quit?

Yes No If you are ready to quit, may we refer you for smoking cessation?

Do you Drink Alcohol? YES NO How many drinks do you have a day? _____

How many times in the past year have you had 4 or more drinks in a day? None 1 day more than 1 day # ____

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you drink caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No Coffee - How many drinks do you have a day? ____ <input type="checkbox"/> Yes <input type="checkbox"/> No Tea - How many drinks do you have a day? ____ <input type="checkbox"/> Yes <input type="checkbox"/> No Soda - How many drinks do you have a day? ____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you follow any special diet every day? (Ex: Atkins, vegetarian) If so, what kind?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you sexually active? <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both How many #(s) of partners had you had in the past? Do you have any history of STD's? If so, state diagnosis.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you regularly exercise? <input type="checkbox"/> Cardiovascular (Ex: running, bootcamp cycling) How many times per week? <input type="checkbox"/> Weight training (Ex: weights, calisthenics) How many times per week?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use any recreational drugs? (Ex: heroin, cocaine, marijuana, pain killers) What drug you use? _____ How often do you use?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any trouble <input type="checkbox"/> falling asleep <input type="checkbox"/> staying asleep <input type="checkbox"/> hot flashes?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you employed? If so, list job title. _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Student