Patient Registration Form

Adult & Pediatric Urgent & Routine Care

Today's Date ______________________________

(Please Print Clearly)

We Do Not Participate In Workman's Compensation or No Fault

PATIENT INFORMATION

Patient's Name _________________________ _________________________ _________ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Last *First* *Middle Initial*

Patient's Address ____
Number & Street *City* *State* *Zip*

Email __________________________________ Home Ph. (____) _______________ Cell Ph. (____) _______________

Date of Birth ______/______/______ Sex ☐ M ☐ F Patient Social Security # ______________________________

Employer ____ Ph. (_____)____________________

Reason for today's visit ____

____

IN CASE OF EMERGENCY

Name of Emergency Contact Person ____

Relationship To Patient ____ Ph. (_____) ___________________

AUTHORIZATION TO TREAT

I hereby authorize StatHealth Immediate Medical Care, PC and its staff to provide me with medical treatment. I agree to inform StatHealth, PC if I have any concerns about my medical treatment at the time services are rendered. The above information is true to the best of my knowledge. I authorize StatHealth or Insurance Company to release any information in processing any claims. I authorize any "In-Network" insurance benefits to be paid directly to StatHealth Immediate Medical Care, PC. I agree to pay for all Urgent care services in full at the time such services are rendered. I understand that I am financially responsible for all Urgent Care charges whether or not paid for by my insurance. I understand that if symptoms persist or get worse I should seek additional medical care.

Patient/Legal Guardian Signature **X**____ Date _____/_____/_____

HIPAA PRIVACY NOTIFICATION

I have received the HIPAA Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/Legal Guardian Signature **X**____ Date _____/_____/_____

LOCATIONS

Smithtown	Port Jefferson Station	Cutchogue	Deer Park	Plainview
(631) 360-5900	(631) 474-5900	(631) 734-5505	(631) 254-5900	Opening Summer 2012
519 West Jericho Turnpike	4724 Nesconset Highway	32645 Main Road	1930 Deer Park Avenue	
Smithtown, NY 11787	Port Jefferson Station, NY 11776	Cutchogue, NY 11935	Deer Park, NY 11729	

General Medical History

Patient's Name ___________________________ ______________________

Age ___________ Date of Birth ______/______/______ Sex ☐ M ☐ F

Please answer the following questions. If you do not know the answer, please circle the question.

Please list all hospitalizations, surgeries and related dates

____

____

Drug allergies ____

Medications you are currently taking ____

Please check if you, your parents, siblings or children have ever been diagnosed with any of the following:

☐ Heart disease ☐ High blood pressure ☐ Cancer ☐ Diabetes ☐ Stroke

If yes, please list relationship ____

Please list any other family illness ____

Do you currently smoke? ☐ Yes ☐ No If no, are you a former smoker? ☐ Yes ☐ No

If yes, how many packs per day? __________

Drink alcohol? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Have you ever been diagnosed with any of the following?

Yes	No	
☐	☐	Eye trouble glaucoma, cataracts or surgery
☐	☐	Wear glasses or contacts
☐	☐	Difficulty hearing speech
☐	☐	Ringing in ears
☐	☐	Frequent or severe headaches
☐	☐	Dizziness, vertigo or balance problems
☐	☐	Severe shortness of breathe
☐	☐	Asthma
☐	☐	Hay fever requiring medicine or shots
☐	☐	Chronic cough or colds
☐	☐	Bronchitis or emphysema
☐	☐	Tuberculosis
☐	☐	Rib fractures
☐	☐	Heart murmur
☐	☐	High blood pressure
☐	☐	Heart attack
☐	☐	Severe palpitations or irregular heartbeat
☐	☐	Chest pains
☐	☐	Hepatitis, liver trouble or jaundice
☐	☐	Persistent indigestion or reflux
☐	☐	Colitis or recurrent
☐	☐	Kidney trouble or kidney stones
☐	☐	Recurrent urinary tract infections
☐	☐	Cancer
☐	☐	Breast disease

Yes	No	
☐	☐	Frequent chills, fever or night sweats
☐	☐	Muscle or joint problems
☐	☐	Arthritis
☐	☐	Knee Pain
☐	☐	Broken or fractured bones
☐	☐	Easy bleeding or bruising
☐	☐	Swelling of ankles or varicose veins
☐	☐	Brain injury or stroke
☐	☐	Seizure, convulsions, epilepsy or paralysis
☐	☐	Skin disease including changes in mole
☐	☐	Depression or mental illness
☐	☐	Prior drug or alcohol treatment
☐	☐	Wear special medical devices implants
☐	☐	Recent weight gain or loss
☐	☐	Concussions
☐	☐	Hernia
☐	☐	Anemia
☐	☐	Diabetes

Other medical illness? ______________________________

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If yes to above please identify and describe __________

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