

Patient Registration Information

Please read and complete all sections. Please sign and date where indicated

| | | | | |
|---------------------------------|--|--|------------------|--------------------|
| Last Name | First Name | Middle Name and Suffix | Sex | Previous Last Name |
| Date of Birth | Social Security Number | Street Address | State | Zip Code |
| Home Phone (all with area code) | Work Phone | Cell Phone | Confidential fax | |
| Your private Email address | How do you prefer we contact you? | Who is your usual health care provider(s)? | | |
| Name of Employer | How did you hear about Dr. Frisenda or who referred you? | | | |
| Emergency Contact Name | Emergency Contact Relation to you or to patient | Emergency Contact Cell /Home Phone # | | |

Guarantor Information

This is the person responsible for payment of services. If the patient is the guarantor, omit this section and proceed to “Insurance Info”

| | | | | |
|---|---------------------------|----------------------|------------------------------|--------------------|
| Patient relationship to Guarantor (parent, guardian , POA etc). | Guarantor Last Name | Guarantor First Name | Guarantor M. name and suffix | |
| Guarantor Date of Birth | Guarantor Street address | Guarantor City | Guarantor State | Guarantor Zip Code |
| Guarantor Social Security Number | Guarantor Cell/Home Phone | Guarantor Employer | | |

Insurance Information

| | | | | |
|--|---------------|------------------|-------------|----------|
| Name of Primary Insurance (Please give the COMPLETE name of the policy) | | Phone # | | |
| Address | | City | State | Zip Code |
| Insurance ID # | Policy Holder | Type of coverage | Local/Group | |
| Name of Secondary Insurance (Please give the COMPLETE name of the policy) | | Phone # | | |
| Address | | City | State | Zip Code |
| Insurance ID # | Policy Holder | Type of coverage | Local/Group | |

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help Dr. Frisenda better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

Allergy

Reaction

1. _____

2. _____

If more space is needed, please use the space below

FAVORITE PHARMACY (including location/town)

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over the counter drugs, such as vitamins and inhalers

DRUG NAME

STRENGTH

FREQUENCY TAKEN

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

If more space is needed, please use the space below

PAST MEDICAL HISTORY (if not listed below, please write in here): ☺

Please check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Leg/Foot Ulcers |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Has Pacemaker | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Clots (or DVT) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer what type? _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hiatal Hernia or Reflux Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Reflux or Ulcers |
| <input type="checkbox"/> Diabetes - Insulin | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes – Non-Insulin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Overactive Thyroid | <input type="checkbox"/> Other(use space below) |

PAST SURGICAL HISTORY

| SURGERY | REASON | YEAR | DOCTOR/HOSPITAL |
|----------------|---------------|-------------|------------------------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |

FAMILY HEALTH HISTORY

List any First degree Blood Relative (parent, brother, sister, children) who contracted a serious medical illness **before age 60**

| Relative | Disease Contracted | Age Contracted |
|----------|--------------------|----------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |

If more space is needed, please use the space below.

Please check all that apply

SOCIAL HISTORY

| | | |
|---|--|---|
| <p>Occupation: _____</p> <p>Education: <input type="checkbox"/> Less than 8th grade</p> <p><input type="checkbox"/> High School <input type="checkbox"/> Two year college</p> <p><input type="checkbox"/> Four year college <input type="checkbox"/> Postgraduate</p> <p>Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic partner</p> <p>Exercise level: <input type="checkbox"/> None or occasional</p> <p> <input type="checkbox"/> Moderate exercise</p> <p> <input type="checkbox"/> High level exercise</p> | <p>Caffeine:</p> <p>Number of Cups of caffineated beverage/day: _____</p> <p>Alcohol: Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, how often?</p> <p> <input type="checkbox"/> Occasional <input type="checkbox"/> less than 3 drinks/wk</p> <p> <input type="checkbox"/> over 3 drinks/week</p> <p>How many drinks/week? _____</p> | <p>Tobacco: Do you use Tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If not currently, did you ever use it <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What year did you quit? _____</p> <p><input type="checkbox"/> Cigarettes: _____/pks/day #of years: _____</p> <p>Drugs</p> <p>Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list: _____</p> |
|---|--|---|

REVIEW OF SYSTEMS

Please check all that apply:

| | | | | |
|--|--|--|---|--|
| <p>Allergic/Immunologic</p> <p><input type="checkbox"/> Frequent Sneezing</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Runny Nose</p> <p><input type="checkbox"/> Sinus Pressure</p> <p>Cardiovascular</p> <p><input type="checkbox"/> Arm Pain on Exertion</p> <p><input type="checkbox"/> Chest Pain on Exertion</p> <p><input type="checkbox"/> Chest Heaviness/ Pressure on Exertion</p> <p><input type="checkbox"/> Irregular Heart Beats (Palpitations)</p> <p><input type="checkbox"/> Known Heart Murmur</p> <p><input type="checkbox"/> Lightheaded on standing</p> <p><input type="checkbox"/> Shortness of Breath when laying down</p> <p><input type="checkbox"/> Shortness of Breath when walking</p> <p><input type="checkbox"/> Swelling (edema)</p> | <p>Constitutional</p> <p><input type="checkbox"/> Exercise Intolerance</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Weight Gain (_____ lbs)</p> <p><input type="checkbox"/> Weight Loss (_____ lbs)</p> <p>Eyes</p> <p><input type="checkbox"/> Dry Eyes</p> <p><input type="checkbox"/> Irritation</p> <p><input type="checkbox"/> Visual Change</p> <p><input type="checkbox"/> Date of last exam: _____</p> <p>Ears/Nose/Mought/Throat</p> <p><input type="checkbox"/> Bleeding Gums</p> <p><input type="checkbox"/> Difficulty Hearing</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Frequent Infections</p> <p><input type="checkbox"/> Frequent Nosebleeds</p> | <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Mouth breathing</p> <p><input type="checkbox"/> Mouth Ulcers</p> <p><input type="checkbox"/> Nose/Sinus Problems</p> <p><input type="checkbox"/> Ringing in Ears</p> <p>Endocrine</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Low Thyroid function</p> <p><input type="checkbox"/> Increase Thirst/ Hunger/Urination</p> <p>Gastrointestinal</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Black or Tarry Stools</p> <p><input type="checkbox"/> Change in Appetite</p> <p><input type="checkbox"/> Frequent Indigestion</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Trouble Swallowing</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting Blood?</p> | <p>Genitourinary</p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Difficulty Urinating</p> <p><input type="checkbox"/> Incomplete Emptying</p> <p><input type="checkbox"/> Increase Urine Frequency</p> <p><input type="checkbox"/> Urinary Loss of Control</p> <p>Hematological/Lymphatic</p> <p><input type="checkbox"/> Easy Burising/Bleeding</p> <p><input type="checkbox"/> Swollen Glands</p> <p>Integumentary (Skin)</p> <p><input type="checkbox"/> Changes in Moles</p> <p><input type="checkbox"/> Dry Skin</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Growth of skin lesions</p> <p><input type="checkbox"/> Jaundice (Yellow skin)</p> <p><input type="checkbox"/> Rash</p> | <p>Neurological</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Headaches/Migraines</p> <p><input type="checkbox"/> Memory Loss</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Restless Legs</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Weakness</p> <p>Psychiatric</p> <p><input type="checkbox"/> Anxiety/Stress</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Do not feel safe in Relationship</p> <p><input type="checkbox"/> Mania</p> <p><input type="checkbox"/> Sleep Disorder</p> <p>Respiratory</p> <p><input type="checkbox"/> Cough or/Cough Blood</p> <p><input type="checkbox"/> Snoring/sleep apnea</p> <p><input type="checkbox"/> Wheezing</p> |
|--|--|--|---|--|

Please add any other information about your health that your would like Dr. Frisenda to know here:

Patient, Parent, Guardian, or Caregiver Signature

Date

CLAIMS AUTHORIZATION

Please be advised that payment is due and payable at the time services are rendered. **It is the obligation of the patient to make payment and not that of the insurance carrier or HMO.**

Your Surgeon's Business Office will be glad to complete and submit any and all insurance forms, but follow-up is the responsibility of the contract holder.

1. **Blue Shield Plan or other insurance**

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to Blue Cross and Blue Shield of Greater New York or other insurer.

I also authorize Blue Cross and Blue Shield of Greater New York or other insurer, to disclose to a hospital, health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with Blue Cross and Blue Shield of Greater New York or other insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators."

2. **Medicare**

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by the physician to me. 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 these benefits or the benefits payable for related services."

3. **Medication History Authority**

I authorize Dr. Frisenda and/or his staff to query, electronically and conventionally, all the pharmacies, lab, imaging and other healthcare facilities that I use in order to obtain my medication, allergy and other medical history.

Signature: _____ Print Name _____ Date _____

Notice of Privacy Practices for the Office of Robert A. Frisenda M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please print and sign the last page and bring it to the office.

At the Office of Robert A. Frisenda M.D., we believe that individuals have a right to adequate notice of our policies, procedures and practices with respect to uses and disclosures of protected health information. Robert A. Frisenda M.D. is required by law to maintain the privacy of your health information and to provide you with a notice of our legal duties and privacy practices. We are required to and will abide by the terms in the Notice of Privacy Practices in effect at the time it is provided to you. You have the right to request a paper copy of this Notice of Privacy Practices even if we have provided a copy to you electronically by e-mail.

Robert A. Frisenda M.D. will not use or disclose your individually identifiable or protected health information other than to carry out health care treatment, payment, and/or operations for you, or as required by law. An example of treatment is a visit to our office for the purpose of diagnosis or care of a health issue wherein doctors, nurses, laboratory technicians, medical students and others will share the information about you in the course of your treatment. Payment includes sharing protected health information with an insurer or a third party that may be responsible for collecting payment from a health plan. Healthcare operations means sharing protected health information for the purpose of quality review.

Robert A. Frisenda M.D. will use and disclose protected health information to business associates in the course of providing treatment, securing payment for such treatment, and/or to facilitate health care operations of our practice, to facilitate the requirements of our business associates' contracts, and to comply with requests from other covered entities to carry out treatment, payment or health care operations.

Except for the purposes described above, Robert A. Frisenda M.D. will only use or disclose protected health information with your express written authorization and you may revoke the authorization at any time in writing. The revocation will apply only to future uses and disclosures. Any information Robert A. Frisenda M.D. provides to a third party other than to our business associates or other health care providers with a treatment relationship to you will be de-identified or stripped of any and all personal data which could be used to identify a specific individual.

Robert A. Frisenda M.D. may contact you to provide appointment reminders or to provide you with information about alternative treatments or other health-care services we provide. We may also contact you to raise funds. When receiving communications from us, you may request that we communicate with you at an alternate location or by alternate means and we will make every effort to accommodate your request. You may request that certain uses and disclosures of your protected health information be

restricted. To do so, you must provide the request in writing using the Request for Restriction on Use or Disclosure form available from our office. Robert A. Frisenda M.D. will determine if the information constitutes required information to carry out treatment, payment or health care operations. If, in our sole opinion, your request does not involve information that is required by us to carry out treatment, payment or health care operations, we will accept your request for restrictions and will notify you if your request will be honored within 30 days or as required by law.

With respect to your protected health information, you have the right to request and receive the following from Robert A. Frisenda M.D.:

- **Inspection and copying**—You may request a report containing your health information that has been collected by Robert A. Frisenda M.D. for you to inspect or copy. Such requests will be honored within 30 days or as required by law, and you will be notified in writing of Robert A. Frisenda M.D.'s receipt of the request and the date upon which the information will be available to you.
- **Amendment or correction**—You may request that we amend or correct your health information that has been collected by Robert A. Frisenda M.D.. Upon agreement by your health care provider, requests to amend health information will be honored within 30 days or as required by law, and you will be notified in writing of Robert A. Frisenda M.D.'s action taken.
- **Accounting of the disclosures**—You may request that we supply you with a listing of the disclosures of your protected health information which have been made by Robert A. Frisenda M.D. except those made for treatment, payment or health care operations, those required by the Final Privacy Rule or made pursuant to other law, and those made pursuant to your explicit authorization. Such requests will be honored within 30 days or as required by law, and you will be notified in writing of the date on which the accounting will be available to you. At a minimum, the accounting of disclosures will include the following information:
 - Date of each disclosure
 - Name and address of the organization of person who received the protected health information

Robert A. Frisenda M.D. has also required in our business associate contracts that they offer a means to provide such a listing for you. If you believe that your privacy rights have been violated or if you request additional information, you may send questions or complaints about this notice or Robert A. Frisenda M.D.'s privacy practices to us and/or to the Secretary of the Department of Health and Human Services (HHS) at 200 Independence Ave. SW, Washington, DC 20201. Such communication with Robert A. Frisenda M.D. should be directed to: Chief Privacy Officer, Robert A. Frisenda M.D., 52 Hooker Ave., Poughkeepsie, N.Y. 12601 or call 845-471-5115. Robert A. Frisenda M.D. will not retaliate against you for filing a complaint with the Secretary of HHS. Robert A. Frisenda M.D. reserves the right to revise this Notice of Privacy Practices at any time without prior notification. You may request a copy of the revised notice and we will provide it to you. This Notice of Privacy Practices is effective as of 4/14/03

Acknowledgment Form for the Notice of Privacy Practices

Robert A. Frisenda M.D., 52 Hooker Ave., Poughkeepsie, N.Y. 845-471-5115

BY FEDERAL LAW, WE ARE REQUIRED TO PROVIDE YOU WITH OUR NOTICE OF PRIVACY PRACTICES (LOCATED ABOVE AND ONLY SUMMARIZED BELOW). THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE NOTICE IS TWO (2) PAGES LONG.

Summary:

As a patient, you have the following rights:

1. The right to inspect and copy you information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communication;
5. The right to a report of disclosures of your information;
6. The right to a paper copy of the Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

Acknowledgment of Notice of Privacy Practices

“I hereby acknowledge that I have received a copy of this practice’s NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact Robert A. Frisenda M.D. at 845-471-5115.”

“I further understand that Robert A. Frisenda M.D will offer me updates to the **Notice of Privacy Practices** should it be amended, modified, or changed in any way. I, the undersigned, acknowledge that I have reviewed and understand the **Notice of Privacy Practices** . All of my questions have been answered.”

Signature: _____ Date: _____
Patient or Representative Name (please sign)

Print Name: _____
Patient or Representative Name (please print)

Patient refused to sign Patient was unable to sign

Reason: _____