Patient Name: _____

Date:_____ Allergies:_____

Name:_____ Date of Birth:_____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Name of Employer:_____ Profession:_____

Address:_____ City:_____ State:_____ Zip:_____

Business Phone:_____ Referred by_____

Name of Primary Care Doctor:_____ Phone:_____

QUESTIONS_____

1. Reason for Today's visit:_____

2. How long have you had this problem?_____
3. What was the approximate date of onset?_____
4. Did your symptoms begin suddenly or gradually?_____
5. What symptoms presented on onset?_____
6. Please circle if you have any of the following symptoms:
   Chronic Sore Throat , Tender neck , Muscle pain,Joint Swelling, Headaches
   Un-refreshing Sleep , Post-exertional fatigue lasting more than 24 hours
7. Do you have widespread pain/fatigue for more than 3 months? Yes or No.
8. Have you had tingling, numbness or extreme weakness in any area of your body?_____
9. How many hours do you work now, if any?_____
10. Have you had any severe infections or injury that required hospitalization?

    Year: _____ Reason:_____

    Year:_____ Reason:_____

11. Please list all current medications with dose:
    - _____
    - _____
    - _____
    - _____
    - _____

12.Please list all over-the-counter medications or supplements:

- _____
- _____
- _____
- _____

Women only:

13.Do you have a regular menses (period) or irregular menses?_____
14. Are you menopausal? Yes or No
15. Have you been on birth control pills or hormone replacement therapy? Y N

Disordered Sleep

16. Do you have trouble falling asleep/ or staying asleep? Mild or Severe circle
17.How many hours of sleep do you get? _____
18.Do your legs jump or kick at night? Yes or No.
19.Does your spouse or significant other say you snore? Yes or No.
20. Do you take medication to sleep? Yes or No. If yes, what medication_____

Infections(Viral, Bacteria, Fungal)

21.Do you have a history of tick bites associated with rashes? Yes or No.
22.Have you ever been treated for Lyme disease? Yes or No.
23. Do you get sores around your mouth, lips or genitals? Yes or No.
24. Have you taken Valtrex or any antibiotic for one month or more? Yes or No
25. Does it burn when you urinate? Yes or No.
26. Have you taken acid reflux medications for one month or more? Yes or No
27. Does your stomach get bloated within 2 hours of a meal? Yes or No.
28. Do you have chronic constipation? Yes or No. Chronic Diarrhea? Yes or No.
29. Do you have athlete's foot, jock itch, nail infections? Yes or No.
30. Do you suffer from frequent sinus infections? Yes or No.
31. Do you suffer from bad breath? Yes or No.

Nutrition

32. Are you vegetarian? Yes or No
33.Do you eat red meat? Yes or No. How often? _____
34. Do you eat fish? Yes or No. How often? _____
35.Do you drink alcohol? Yes or No. How many glasses a week? _____

36. Do you drink milk? Yes or No. Do you eat cheese? Yes or No.
37. Do you crave sugar products? Yes or No.
38. Do you crave salt products? Yes or No.
39. Do you drink regular sodas daily? Yes or No. Diet sodas? How many glasses? _____
40. Do you smoke cigarettes? Yes or No. Did you smoke in the past? How much?_____

Cardiovascular/ Health

41. Can you walk several blocks without stopping? Yes or No.
42. Can you walk up 1 or 2 flights of stairs? Yes or No. If no, why not?
    _____
43. Do you get swelling in your legs when walking too long? Yes or No.
44. Can you carry your groceries from the store? Yes or No.
45. Do you ever experience your heart racing or skipping a beat? Yes or No.
46. Do you ever experience chest pain? Yes or No.
47. Has your weight changed in the past 6 months? Yes or No. If so, is it 10 to 15 lbs more or less than before?_____

Family History

48. Please list the medical conditions of your family- if deceased please note cause and age:
    Mother_____ Father_____
    Brother_____ Sisters_____

Please list and forward prior **Radiology** and **Lab reports** to office:

- _____
- _____
- _____

Social/Stress Index

49. Do you live alone? Yes or No.
50. Do you have someone you could call nearby in an emergency? Yes or No.
51. Do you care for a young child or an elderly relative? Yes or No.

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.

Immunology, Alternative and Integrative Medicine

57 West 57th Street, #601
New York, NY 10019

165 North Village Ave., #129
Rockville Centre, NY 11570

Date:_____

PATIENT'S NAME: (Last)_____(First)_____

ADDRESS: (Home)_____

CITY & STATE:_____**ZIP CODE:**_____

SEX: ( ) **M** ( ) **F** **AGE:**_____**BIRTHDATE:**_____**SSN:**_____

PHONE: (Business)_____(Home)_____

CELL PHONE NUMBER:_____

E-MAIL ADDRESS:_____

COMPANY NAME:_____

ADDRESS:_____**OCCUPATION:**_____

CITY & STATE:_____**ZIP CODE:**_____

REASON FOR BEING HERE:_____

HAVE YOU BEEN HERE BEFORE:_____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE:_____

ARE YOU ALLERGIC TO ANY MEDICATION:_____

CURRENT MEDICATION:_____

NAME OF INSURANCE CARRIER:_____

NAME OF POLICY HOLDER:_____**ID#:**_____

POLICY HOLDER'S DATE OF BIRTH:_____**SSN:**_____

ARE YOU OR YOUR SPOUSE COVERED BY ANY OTHER MEDICAL INSURANCE_____**YES**_____**NO**

IF YES, PLEASE GIVE INSURANCE CARRIER AND POLICY NUMBER:_____

_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED:_____

_____

To the best of my knowledge, the insurance information I have provided is correct. If for any reason, my visit or medical procedure deemed necessary by my physician is denied or if my insurance is not valid, I agree to be fully responsible for the fees and services rendered to me. If I provide any wrong information or if my bill goes to collection, I will be responsible for my bill in its entirety and any collection fees.

ALSO I HAVE REVIEWED AND SEEN THE PRACTICE'S PRIVACY NOTICE

PATIENT'S OR GUARDIAN'S SIGNATURE: _____

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION & WRITTEN RECEPIT OF NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Mitchell Medical Group of NY, P.C. to use and disclose Protected Health Information (PHI) about me to carry out **Treatment, Payment and Healthcare Operations (TPO).** Mitchell Medical Group of NY, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Mitchell Medical Group of NY, P.C. reserves the right to change Notice of Privacy Practices at anytime. A revised Notice of Privacy may be obtained by forwarding a written request to Mitchell Medical Group of NY, P.C., Privacy Officer at 165 N. Village Ave., #129 Rockville Center, NY 11570 or 57 West 57th Street, #601 New York, NY 10019

PLEASE CROSS OFF EACH ITEM BELOW THAT YOU DO NOT WANT TO ALLOW US TO DO! (If any one is a no, then whole number is out)!

With this consent Mitchell Medical Group of NY, P.C. may:

1) Call my home or cell phone and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory & biopsy results among others.
2) At any alternative location, the practice will only leave a message on my personal voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory & biopsy results among others. **However, at any alternative location call Mitchell Medical Group of NY will not leave a message about my medical condition or lab results with any person.**
3) May mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements.
4) May e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements and practice updates.

I have the right to request that Mitchell Medical Group of NY, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Mitchell Medical Group of NY, P.C.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Mitchell Medical Group of NY, P.C. may decline to provide treatment to me.

I have received a copy of Mitchell Medical Group of NY, P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian | Print Name of Patient's Legal Guardian

_____ _____

Patient's Name | Date

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.
Immunology, Alternative and Integrative Medicine

57 West 57th Street, #601
New York, NY 10019
Tele: 212-586-7400

165 North Village Ave., #129
Rockville Centre, NY 11570
Tele: 516-678-9600

Prescription Form

Patient Name: _____

DOB: _____

By signing this prescription form, I request and authorize the shipment of my compounded medication to office's of Mitchell Medical Group of New York, P.C..

_____
Patient Signature

_____
Date

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.
Immunology, Alternative and Integrative Medicine

165 N. VILLAGE AVE, #129
ROCKVILLE CENTRE, NY 11570
TELE: 516/678-9600
FAX: 516/678-9618

57 WEST 57th STREET, #601
NEW YORK, NY 10019
212/586-7400
212/586-6880

ADVANCED BENEFICIARY NOTICE

I, _____, have been made aware by the staff at Mitchell Medical Group of New York, P.C. that I may not be reimbursed for medical services rendered to me.

I fully understand that any procedure not covered by my insurance is my responsibility.

_____
Patient Name

_____
Date

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.
Immunology, Alternative and Integrative Medicine

57 West 57th Street, #601
New York, NY 10019

165 North Village Ave., #129
Rockville Centre, NY 11570

DUE TO EXCESSIVE CANCELLATIONS AND

NO SHOWS, WE WILL BE REQUIRING ALL PATIENTS

TO CANCEL WITHIN

48 HOURS INSTEAD OF 24 HOURS.

IF A PATIENT CANCELS OR DOES NOT SHOW,

THEY WILL BE CHARGED FOR THEIR VISIT.

WE NEED TO BE ABLE TO ACCOMMODATE O

THER PATIENTS WHO WISH TO COME IN.

WE ARE SORRY FOR ANY INCONVENIENCE.

_____ _____

Signature of Patient or Legal Guardian Signature of Patient or Legal Guardian

_____ _____

Patient Name Date