

PATIENT HISTORY FORM

DATE: _____

NAME: _____ **AGE:** _____ **DOB:** _____

ADDRESS: _____

SEX: ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other _____

Home/Cell#: _____ **Email:** _____

Emergency Contact Name: _____ **Their Contact #:** _____

Employer: _____ **Profession:** _____

Work#: _____ **Business address:** _____

Primary Care Doctor: _____ **Referred by:** _____

Reason for your Visit:

How long have you had this problem: _____

When was the approximate date of onset: _____

Did your Symptoms begin: ☐ Suddenly or ☐ Gradually

Which symptoms presented on onset: _____

Please Choose any of they symptoms you currently have:

☐ Chronic Sore Throat ☐ Tender Neck ☐ Muscle pain ☐ Joint Swelling ☐ Headaches

☐ Un-refreshing Sleep ☐ Post-exertional fatigue lasting more than 24 hours

Do you have widespread pain/fatigue for more than 3 months: ☐ YES ☐ NO

Have you had tingling, numbness or extreme weakness in any area of your body: ☐ YES ☐ NO

If yes, briefly describe: _____

How many hours do you work now (if none – write none): _____

Have you had any severe infections and/or injury that required hospitalization? ☐ YES ☐ NO

If YES: Year: _____ **Reason:** _____

Year: _____ **Reason:** _____

Please list all current Medications with Dosage for each:

RX: _____ Dosage: _____ RX: _____ Dosage: _____
 RX: _____ Dosage: _____ RX: _____ Dosage: _____
 RX: _____ Dosage: _____ RX: _____ Dosage: _____

Please list all Over the Counter medications and supplements with Dosage of each:

OTC: _____ Dosage: _____ OTC: _____ Dosage: _____
 OTC: _____ Dosage: _____ OTC: _____ Dosage: _____

Section for WOMEN only

Did you have regular menses(period)? ☐ YES ☐ NO Irregular menses ☐ YES ☐ NO Menopausal ☐ YES ☐ NO
 Have you been on birth control pills and/or hormone replacement therapy? ☐ YES ☐ No

Disordered Sleep

Do you have trouble falling asleep? ☐ YES ☐ NO Staying Asleep? ☐ YES ☐ NO Mild or Severe? ☐ YES ☐ NO
 How many hours sleep of sleep/day do you get: _____ Do your legs jump or kick at night ☐ YES ☐ NO
 Have you been told by others that you snore? ☐ YES ☐ NO Do you take sleep medication ☐ YES ☐ NO
 Type of sleep medication you take (if applicable): _____

Infections (Viral; Bacterial; Fungal)

Do you have a history of rashes associated with tick bites ☐ YES ☐ NO Ever treated for Lyme disease ☐ YES ☐ NO
 Do you get sores around your mouth; lips or genitals ☐ YES ☐ NO Does it burn when you urinate ☐ YES ☐ NO
 Ever taken Valtrex® or any antibiotic for 1 month or more ☐ YES ☐ NO Do you suffer from bad breath ☐ YES ☐ NO
 Have you taken acid reflux medications for a month or more ☐ YES ☐ NO Chronic Diarrhea ☐ YES ☐ NO
 Does your stomach get bloated within 2 hours of a meal ☐ YES ☐ NO Chronic constipation ☐ YES ☐ NO
 Do you have athlete's foot; jock itch and/or nail infections ☐ YES ☐ NO Frequent Sinus infections ☐ YES ☐ NO

Nutrition

Are you a Vegetarian ☐ YES ☐ NO Vegan ☐ YES ☐ NO Eat Red Meat ☐ YES ☐ NO how often: _____
 Do you eat fish ☐ YES ☐ NO how often: _____ Drink Alcohol ☐ YES ☐ NO how often: _____
 Do you drink milk ☐ YES ☐ NO Eat Cheese ☐ YES ☐ NO Do you crave sugar products ☐ YES ☐ NO
 Do you crave salt products ☐ YES ☐ NO Do you drink regular soda daily ☐ YES ☐ NO Diet Soda ☐ YES ☐ NO
 If you drink either regular soda or diet sodas – how many glasses/day: _____
 Do you smoke cigarettes? ☐ YES ☐ NO Did you smoke in the past ☐ YES ☐ NO How much/day: _____

Cardiovascular Health

Can you walk several blocks no stopping ☐ YES ☐ NO Walk 1 or 2 flights of stairs ☐ YES ☐ NO If No, why not: _____
 Do your legs swell if walk too long ☐ YES ☐ NO
 Capable of carrying groceries from store ☐ YES ☐ NO Experience heart racing or skipping a beat ☐ YES ☐ NO
 Ever experience chest pain ☐ YES ☐ NO Weight change in last 6 months ☐ YES ☐ NO
 If yes to weight change, is it 10-15 lbs more or less than prior 6 months ☐ YES ☐ NO

FAMILY HISTORY

Please list the medical conditions of your family. If deceased, please note cause of death and age of the deceased family member

☐ Mother	Medical Conditions: _____	If deceased: _____
☐ Father	Medical Conditions: _____	If deceased: _____
☐ Brother	Medical Conditions: _____	If deceased: _____
☐ Brother	Medical Conditions: _____	If deceased: _____
☐ Brother	Medical Conditions: _____	If deceased: _____
☐ Sister	Medical Conditions: _____	If deceased: _____
☐ Sister	Medical Conditions: _____	If deceased: _____
☐ Sister	Medical Conditions: _____	If deceased: _____

Please List **Prior Radiology and Lab reports** and forward listed reports to our office:

☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

Social/Stress Index

Do you live alone ☐ **YES** ☐ **NO** If No, who lives with you: _____

Do you have someone you can call, that is nearby, in an emergency ☐ **YES** ☐ **NO**

Do you care for a young child ☐ **YES** ☐ **NO** Do you care for an elderly relative ☐ **YES** ☐ **NO**

DATE: _____

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

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SEX: ☐ M ☐ F AGE: _____ BIRTHDATE: _____ SSN: _____

PHONE(Business): _____ (Home): _____

CELLPHONE NUMBER: _____ EMAIL: _____

COMPANY NAME: _____

ADDRESS: _____ OCCUPATION: _____

CITY/STATE: _____ ZIP CODE: _____

REASON FOR BEING HERE: _____

HAVE YOU BEEN HERE BEFORE: ☐ YES ☐ NO

HOW DID YOU FIND OUT ABOUT OUR PRACTICE: _____

ARE YOU ALLERGIC TO ANY MEDICATION: _____

CURRENT MEDICATION(S): _____

NAME OF INSURANCE COMPANY: _____

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 WE NOTIFY: _____

EMERGENCY CONTACT #: _____

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 associated collection fees.

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

PATIENT OR GUARDIAN'S SIGNATURE: _____

**PATIENT CONSENT FOR USE AND DISCLOSURE ON PROTECTED HEALTH INFORMATION AND
WRITTEN RECEIPT 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 any time. 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.

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

NOTE: CHECK Any section below ONLY if you DO NOT give consent to our practice as a means of contact – if you CHECK OFF – the Entire consent of the Section checked is Revoked

- ☐ Call my home or cell phone and leave a message on voicemail 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 and biopsy results – or other results.
- ☐ At any alternative location, the practice will only leave a message on my personal voicemail 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 and biopsy results – or other results.
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.
- ☐ 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.
- ☐ May email to my home or other alternative location any items that assist in the practice in carrying out TPO, such as appointment reminder cards, patient statements.
- ☐ May email 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 (please print)

Date

PRESCRIPTION AUTHORIZATION FORM

PATIENT NAME: _____
(Please Print)

DATE OF BIRTH: _____

I request and authorize my compounded medication be shipped directly to the offices of Mitchell Medical Group of NY, P.C.

PATIENT SIGNATURE: _____

DATE: _____

ADVANCED BENEFICIARY NOTICE

I : _____ have been made aware by the staff at Mitchell Medical Group of NY, P.C. that I may not be reimbursed by my insurance plan(s) for any medical services rendered to me by the medical staff at the practice.

I fully understand that the cost of any procedure that is not fully paid for by my insurance plan(s), I am fully responsible for the costs.

Patient Signature: _____

DATE: _____

APPOINTMENT AGREEMENT

The Entire team of Mitchell Medical Group of NY, P.C. is committed to every patient being seen on time. We value all patient's time and commitment to arrive on-time for their appointment. We recognize that circumstances may require you to reschedule your appointment with us. Your agreement to adhere to our appointment parameters ensures prompt and continuous care at our offices. We thank you for your commitment and agreement to abide by the terms below.

I understand and agree to give at least 48-hours' notice to cancel and/or reschedule any appointment I have scheduled with the practice. I understand that if I do not provide 48-hours' notice to cancel and/or reschedule my appointment with the practice, I will be responsible for payment for the services scheduled including the cost of the office visit.

PATIENT SIGNATURE: _____

DATE: _____

PATIENT NAME: _____

Signature of Legal Guardian: _____

DATE: _____

PATIENT PHARMACY INFORMATION

(please print)

DATE: _____

PATIENT NAME: _____

ANY DRUG ALLERGIES: _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE NUMBER: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1 : Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration pursuant to New York law, and not by a lawsuit or resort to court process except as New York law may provide for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. The filing by Physician of any action in any court by the Physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a New York Supreme Court justice to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed the Federal Arbitration Act (9 U.S.C. 1-4), and otherwise applicable New York law. All claims and defenses related to any claim by the patient shall be governed by New York law. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with New York law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician or Duly _____
Authorized Representative Signature Date

By: _____
Patient Signature Date

Patient Name: _____
Please Print

By: _____
Print or Stamp Name of Physician, Medical Group
Or Association Name

By: _____
Patients' Representative Signature Date

By: _____
Signature of Translator Date

Patient Representative: _____
Please Print

Name of Translator: _____

Relationship to Patient: _____