WELCOME

PATIENT INFORMATION

Date_____

Patient Name_____

Address_____

_____

City State Zip

Sex: M ☐ F ☐ Age_____ Birth date_____

Marital Status: ☐Single ☐Married

☐Widowed ☐Separate ☐Divorced

Patient SS# _____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____
Spouse's Name_____
Spouse's Birth Date_____SS#_____
Occupation_____
Spouse's Employer_____
Whom may we thank for referring you?_____

PHONE NUMBERS

PATIENT:

Home_____ Work_____

Cell_____ Email_____

Best time and place to reach you_____

EMERGENCY CONTACT:

Name_____

Relationship_____

Home Phone_____

Work Phone_____ EXT_____

Cell Phone _____

INSURANCE

Who is responsible for this account?_____

Relationship to patient_____

Insurance Co._____

Group#_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber name_____

Birth date _____

Relationship to patient_____

Insurance Co._____

Group#_____

ASSIGNMENT AND RELEASE

I the undersigned certify that I (or my dependent) have insurance coverage with_____ And assign directly to Dr. DeFabritus all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. DeFabritus. For any services furnished me Dr. DeFabritus. 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. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims. My signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

MEDICAL HISTORY

Mark "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ YES	☐ NO	**Diabetes**	☐ YES	☐ NO	Psychiatric Care	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Gout	☐ YES	☐ NO	Radiation Treatment	☐ YES	☐ NO
Angina	☐ YES	☐ NO--	Seizures	☐ YES	☐ NO	Cancer	☐ YES	☐ NO
Bleeding Disorders	☐ YES	☐ NO--	Stroke	☐ YES	☐ NO	Shortness of Breath	☐ YES	☐ NO
Ulcers	☐ YES	☐ NO	Varicose Veins	☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO	**Heart Attack**	☐ YES	☐ NO	Chest Pain	☐ YES	☐ NO
Circulatory Problems	☐ YES	☐ NO	**Kidney Problems**	☐ YES	☐ NO	Swelling in Ankles, Feet	☐ YES	☐ NO
Chemical Dependency	☐ YES	☐ NO	**Kidney Stones**	☐ YES	☐ NO	Jaundice	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	**Kidney Infections**	☐ YES	☐ NO	Phlebitis	☐ YES	☐ NO
Artificial Heart Valves	☐ YES	☐ NO	Liver Disease	☐ YES	☐ NO	Artificial Joints or Valves	☐ YES	☐ NO
Thyroid disorder	☐YES	☐ NO	Hepatitis	☐ YES	☐ NO	Alcohol dependency	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	**High Blood Pressure**	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Weight Loss	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO	Respiratory Disease	☐ YES	☐ NO

Further details on past medical history if you wish:

_____

_____

_____

Use of over-the-counter analgesics (pain-killers) ☐ **YES** ☐ **NO** **If yes, how often?**_____

Previous Operations and dates of surgery_____

_____

Hospitalization other than for the surgeries listed_____

_____

_____

ALLERGIES

☐ **Aspirin** ☐ **Penicillin**
☐ **Codeine, morphine, Demerol**
☐ **Sulfa** ☐ **Iodine**
☐ **Other drug allergies**_____

☐ **NO KNOWN DRUG ALLERGIES**

HABITS

Do you smoke? ☐ **Yes** ☐ **N**
Have you ever smoked?
If Yes, How many packs per day? _____
Do you drink alcohol? ☐ **Yes** ☐ **No**
If Yes, How much do you drink?
_____

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary for the diagnosis and/or treatment of my medical condition, after explanation by the doctor of risks and benefits.

Patient's Signature_____ Date_____

CURRENT MEDICATIONS

Date_____

Patient Name_____

Medication Name (Generic or Brand)	Dose (mg, ml, or grams)	Frequency (times per day or per week)

Albert M. DeFabritus M.D.

36 7th Avenue Suite 418
New York, New York 10011

PLEASE SIGN

We Reserve The Right To Charge for Appointments Missed or Canceled without 24 hours notification.

Date:_____
Signature_____

Albert M. DeFabritus M.D.
36 7th Avenue Suite 418
New York, New York 10011

Patient Acknowledgement of privacy notice:

I_____ have received and read a copy of the office privacy notice.
I am making the following special request for confidential communications.

_____

_____

_____

_____

_____

_____ _____
Signature Date