PATIENT INTAKE FORM

112 Greenpoint Ave, 1B
Brooklyn, NY 11222

Demographics

Name | DOB | Gender | Social

Address, Apt # | City | State | Zip

Phone | E-mail | Emergency Contact/ Contact Number

Insurance Company | Member ID

Last Physical Exam:

What's the reason for your visit?

List medications with dosage:

List known allergies:

Past surgeries:

Currently not taking any medications

No known allergies

No past surgical history

History

Family History

- Hypertension
- Diabetes
- Cancer
- Other

One which side of the family?:

- Maternal
- Paternal

Social History

- Alcohol
- Tobacco
- Marijuana
- Substance Abuse

How often?

Vaccinations:

- Influenza
- TDAP
- Shingles

Females:

Last menstrual period:

Last PAP Smear:

Are you currently:

- Pregnant
- Breast Feeding

Contraception Methods

- Birth Control Pill
- IUD
- Diaphragm
- Spermacide
- Condoms
- Abstinence
- None

The information provided above is accurate and complete to the best of my knowledge

Signature:

Date:

Patient Acknowledgement of Office Polices of Medical Point Health Care

1. Insurance Information

It is patient responsibility to be aware of their insurance policy, including but not limited to: eligibility, co-payment, coinsurance, deductible. I understand that regardless of insurance enrollment, I am responsible for services performed by this office. I understand that if I receive a bill, I am responsible for timely payment.

2. Cancellation Policy

I understand that I will be charged a $35 fee for no show appointments or appointments cancelled within 24 hours of the scheduled time. I understand the card I provide on file will be kept confidential and will not be charged without notice.

Card Number: Exp: CVV: Billing Zip:

3. Authorization for Release of Patient Information

Please check all that apply for release of healthcare information:

E-mail Phone

Voicemail Text Message (appt reminders)

*We do send out occasional emails regarding office updates but we will not flood your inbox!

Please provide the name of any other person or persons (if any) who you authorize your healthcare information to be released to:

4. General Consent for Care and Treatment

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and you consent to treatment at this office or any other satellite office under common ownership. If you have any concerns regarding any test or treatment recommended and/or performed by a health care provider at this facility, we encourage you to ask questions.

5. HIPAA Authorization

I authorize the following entity to receive and discuss my medical records and conditions:

Name of Individual/ Practice

This authorization has no expiration date. However, you have the right to revoke this authorization at any time by submitting a letter to our office at 112 Greenpoint Ave, 1B Brooklyn, NY 11222.
*Please ask receptionist for a full copy of HIPAA if desired.

I certify that I have read and fully understand the statements outlined in this document and consent fully and voluntarily to its contents

Signature: Date