

Patient Registration Form



Today's Date _____

Adult & Pediatric Urgent & Routine Care

(Please Print Clearly)

We Do Not Participate In Workman's Compensation or No Fault

PATIENT INFORMATION

Patient's Name _____ Mr. Mrs. Miss Ms.
Last First Middle Initial

Patient's Address _____
Number & Street City State Zip

Email _____ Home Ph. (____) _____ Cell Ph. (____) _____

Date of Birth ____/____/____ Sex M F Patient Social Security # _____

Employer _____ Ph. (____) _____

Reason for today's visit _____

IN CASE OF EMERGENCY

Name of Emergency Contact Person _____

Relationship To Patient _____ Ph. (____) _____

AUTHORIZATION TO TREAT

I hereby authorize StatHealth Immediate Medical Care, PC and its staff to provide me with medical treatment. I agree to inform StatHealth, PC if I have any concerns about my medical treatment at the time services are rendered. The above information is true to the best of my knowledge. I authorize StatHealth or Insurance Company to release any information in processing any claims. I authorize any "In-Network" insurance benefits to be paid directly to StatHealth Immediate Medical Care, PC. I agree to pay for all Urgent care services in full at the time such services are rendered. I understand that I am financially responsible for all Urgent Care charges whether or not paid for by my insurance. I understand that if symptoms persist or get worse I should seek additional medical care.

Patient/Legal Guardian Signature **X** _____ Date ____/____/____

HIPAA PRIVACY NOTIFICATION

I have received the HIPAA Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/Legal Guardian Signature **X** _____ Date ____/____/____

LOCATIONS

Smithtown
(631) 360-5900
519 West Jericho Turnpike
Smithtown, NY 11787

Port Jefferson Station
(631) 474-5900
4724 Nesconset Highway
Port Jefferson Station, NY 11776

Cutchogue
(631) 734-5505
32645 Main Road
Cutchogue, NY 11935

Deer Park
(631) 254-5900
1930 Deer Park Avenue
Deer Park, NY 11729

Plainview
Opening Summer 2012

General Medical History



Patient's Name _____

Age _____ Date of Birth ____/____/____ Sex M F

Please answer the following questions. If you do not know the answer, please circle the question.

Please list all hospitalizations, surgeries and related dates

Drug allergies _____

Medications you are currently taking _____

Please check if you, your parents, siblings or children have ever been diagnosed with any of the following:

- Heart disease High blood pressure Cancer Diabetes Stroke

If yes, please list relationship _____

Please list any other family illness _____

Do you currently smoke? Yes No If no, are you a former smoker? Yes No

If yes, how many packs per day? _____

Drink alcohol? Daily Weekly Occasionally Never

Have you ever been diagnosed with any of the following?

Yes No

- Eye trouble glaucoma, cataracts or surgery
- Wear glasses or contacts
- Difficulty hearing speech
- Ringing in ears
- Frequent or severe headaches
- Dizziness, vertigo or balance problems
- Severe shortness of breathe
- Asthma
- Hay fever requiring medicine or shots
- Chronic cough or colds
- Bronchitis or emphysema
- Tuberculosis
- Rib fractures
- Heart murmur
- High blood pressure
- Heart attack
- Severe palpitations or irregular heartbeat
- Chest pains
- Hepatitis, liver trouble or jaundice
- Persistent indigestion or reflux
- Colitis or recurrent
- Kidney trouble or kidney stones
- Recurrent urinary tract infections
- Cancer
- Breast disease

Yes No

- Frequent chills, fever or night sweats
- Muscle or joint problems
- Arthritis
- Knee Pain
- Broken or fractured bones
- Easy bleeding or bruising
- Swelling of ankles or varicose veins
- Brain injury or stroke
- Seizure, convulsions, epilepsy or paralysis
- Skin disease including changes in mole
- Depression or mental illness
- Prior drug or alcohol treatment
- Wear special medical devices implants
- Recent weight gain or loss
- Concussions
- Hernia
- Anemia
- Diabetes

Other medical illness? _____

If yes to above please identify and describe _____
