



**PATIENT INFORMATION:**

Please complete all three sections of this page and read the reverse side carefully and sign.

NAME		DATE OF BIRTH	GENDER	MARITAL STATUS
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE # CIRCLE ONE	(OK TO LEAVE MESSAGE?)	CELL PHONE #	(OK TO LEAVE MESSAGE?) CIRCLE ONE	
YES	NO		YES	NO
CONFIDENTIAL FAX #	E-MAIL ADDRESS	PAGER #	SOCIAL SECURITY #	
NAME OF EMPLOYER/SCHOOL	YOUR WORK PHONE # (OK TO LEAVE MESSAGE?) CIRCLE ONE		OCCUPATION	
	YES NO			
ADDRESS	CITY	STATE	ZIP	
IN CASE OF EMERGENCY, CONTACT: NAME			PHONE	
REFERRING PHYSICIAN, PERSON OR INSTITUTION (WHO ADVISED YOU TO BE EVALUATED BY THIS SURGEON)				

**RESPONSIBLE FINANCIAL PARTY (if not the patient):**

NAME (PARENT OR SPOUSE IF INDICATED)		RELATIONSHIP TO PATIENT			
HOME PHONE (OK TO LEAVE MESSAGE?) CIRCLE ONE	BUSINESS PHONE	(OK TO LEAVE MESSAGE?) CIRCLE ONE	CELL PHONE (OK TO LEAVE MESSAGE?) CIRCLE ONE		
YES	NO	YES	NO	YES	NO
ADDRESS	CITY	STATE	ZIP		
E-MAIL ADDRESS	CONFIDENTIAL FAX	DATE OF BIRTH	SOCIAL SECURITY #		
NAME OF THEIR EMPLOYER					
ADDRESS	CITY	STATE	ZIP		

**INSURANCE INFORMATION ( PLEASE OBTAIN THIS INFORMATION FROM INSURANCE ID CARD):**

<b>PRIMARY INSURANCE</b>				
ADDRESS	CITY	STATE	ZIP	
INSURANCE ID #	POLICY HOLDER			
TYPE OF COVERAGE	LOCAL/GROUP			
<b>SECONDARY INSURANCE</b>				
ADDRESS	CITY	STATE	ZIP	
INSURANCE ID #	POLICY HOLDER			
TYPE OF COVERAGE	LOCAL/GROUP			

## CLAIMS AUTHORIZATION

Please be advised that payment is due and payable at the time services are rendered. **It is the obligation of the patient to make payment and not that of the insurance carrier or HMO.**

Your Surgeon's Business Office will be glad to complete and submit any and all insurance forms, but follow-up is the responsibility of the contract holder.

### **1. Blue Shield Plan or other insurance**

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to Blue Cross and Blue Shield of Greater New York or other insurer.

I also authorize Blue Cross and Blue Shield of Greater New York or other insurer, to disclose to a hospital, health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with Blue Cross and Blue Shield of Greater New York or other insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators."

### **2. Medicare**

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by the physician to me. 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."

### **3. Medication History Authority**

I authorize Dr. Frisenda and/or his staff to query electronically and conventionally all the pharmacies, lab, imaging and other healthcare facilities that I use in order to obtain my medication, allergy and other medical history.

Medical Questionnaire Name \_\_\_\_\_ Date \_\_\_\_\_

(Please fill out the back of this sheet also)

I. WHAT SYMPTOM OR PROBLEM BRINGS YOU HERE TODAY? (Why are you here today?)

**II. LIST ALL PAST AND PRESENT MEDICAL CONDITIONS AND/OR HOSPITALIZATIONS.**

For example, high blood pressure, diabetes, etc. (Do not list operations here.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**III. LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS YOU**

**CURRENTLY TAKE. MEDICATION DOSE FREQUENCY/DAY MEDICATION**

<u>DOSE FREQUENCY/DAY</u>	

**IV. LIST ALL ALLERGIES TO MEDICATIONS AND THE REACTIONS YOU EXPERIENCED.**

**MEDICATION REACTION YOU HAD MEDICATION REACTION YOU HAD**


**V. LIST ALL OPERATIONS, ALSO, ANY ADVERSE REACTION TO THE ANESTHETIC OR SURGERY.**

**OPERATION ADVERSE REACTION (IF ANY) OPERATION ADVERSE REACTION (IF ANY)**


**VI. ANESTHESIA HISTORY**

HAS ANYONE IN YOUR FAMILY HAD A SERIOUS REACTION TO AN ANESTHETIC (GENERAL, SPINAL, OR LOCAL)? IF SO, PLEASE DESCRIBE.

\_\_\_\_\_

DO YOU HAVE ANY OF THE FOLLOWING (please circle): UPPER DENTURES, LOWER DENTURES, CAPS, LOOSE TEETH, CHIPPED TEETH, CONTACT LENSES, SLEEP APNEA, REFLUX OR HIATAL HERNIA (GERD), LATEX ALLERGY, TMJ HISTORY OF A HEART ATTACK, HEART FAILURE, HEART EVALUATION, HYPERTHERMIA DURING ANESTHESIA (YOU OR A RELATIVE), KIDNEY FAILURE, TAKE BLOOD THINNERS, PREDNISONE OR INSULIN

VII. HOW MANY DAYS PER MONTH DO YOU DRINK ALCOHOLIC BEVERAGES? \_\_\_\_  
What? \_\_\_\_\_ How much per day on the days that you do drink? \_\_\_\_\_

IF YOU CURRENTLY SMOKE OR HAD SMOKED, HOW MANY PACKS PER DAY AND FOR HOW MANY YEARS? \_\_\_\_\_ packs per day \_\_\_\_\_ years currently smoking? (circle) yes no never

**VIII. LIST ANY FIRST DEGREE BLOOD RELATIVE (parent, brother, sister, children) WHO DEVELOPED A SERIOUS MEDICAL ILLNESS BEFORE AGE 60.**

**RELATIVE DISEASE CONTRACTED AGE CONTRACTED**

\_\_\_\_\_  
\_\_\_\_\_

OVER

Name: \_\_\_\_\_ Date: \_\_\_\_\_

LIST YOUR: HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ USUAL BLOOD PRESSURE (if you know it) \_\_\_\_\_

**X. HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS (PLEASE CHECK IF YES)**

NOW PAST

<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Fever with chills
<input type="checkbox"/>	<input type="checkbox"/>	Skin trouble/change
<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding/bruising
<input type="checkbox"/>	<input type="checkbox"/>	Transfusions
<input type="checkbox"/>	<input type="checkbox"/>	History of Blood Clots
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Seizures (fits)
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears
<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	Other ear trouble
<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	<input type="checkbox"/>	Trouble swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums
<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Hayfever
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood
<input type="checkbox"/>	<input type="checkbox"/>	Positive T.B. test
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Family history of Colon cancer
<input type="checkbox"/>	<input type="checkbox"/>	Family history of Pancreatic cancer
<input type="checkbox"/>	<input type="checkbox"/>	Family history of Prostate cancer

NOW PAST

<input type="checkbox"/>	<input type="checkbox"/>	Chest pains
<input type="checkbox"/>	<input type="checkbox"/>	Heart attacks
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Valvular heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmurs
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations (rapid heart)
<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles
<input type="checkbox"/>	<input type="checkbox"/>	Calf (leg) pain with walking
<input type="checkbox"/>	<input type="checkbox"/>	Heart condition /failure
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood
<input type="checkbox"/>	<input type="checkbox"/>	Yellow jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Bloody B.M.'s
<input type="checkbox"/>	<input type="checkbox"/>	Black B.M.'s
<input type="checkbox"/>	<input type="checkbox"/>	Stomach cramps/pain
<input type="checkbox"/>	<input type="checkbox"/>	Colitis/spastic colon
<input type="checkbox"/>	<input type="checkbox"/>	Bloating
<input type="checkbox"/>	<input type="checkbox"/>	Belching
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers (stomach)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Urine stream slow or poor
<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Urination at night
<input type="checkbox"/>	<input type="checkbox"/>	Urine infection
<input type="checkbox"/>	<input type="checkbox"/>	Bloody urine
<input type="checkbox"/>	<input type="checkbox"/>	Kidney failure
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Urine incontinence
<input type="checkbox"/>	<input type="checkbox"/>	Cystoscopy
<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands
<input type="checkbox"/>	<input type="checkbox"/>	Joint pain
<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps

NOW PAST

<input type="checkbox"/>	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	Slipped disc
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Increased thirst
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble
<input type="checkbox"/>	<input type="checkbox"/>	Mental illness
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Excessive worry
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide
<input type="checkbox"/>	<input type="checkbox"/>	Sexual problem
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol problem
<input type="checkbox"/>	<input type="checkbox"/>	Drug problem
<input type="checkbox"/>	<input type="checkbox"/>	Emotional problem
<input type="checkbox"/>	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	Latex allergy
		<b>FOR WOMEN ONLY</b>
<input type="checkbox"/>	<input type="checkbox"/>	Tube infection
<input type="checkbox"/>	<input type="checkbox"/>	PAP smear abnormal
<input type="checkbox"/>	<input type="checkbox"/>	PAP, last done more than 3 years ago
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding after menopause
<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal mammogram
<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge
<input type="checkbox"/>	<input type="checkbox"/>	Breast cancer (you)
<input type="checkbox"/>	<input type="checkbox"/>	Family history of breast cancer
<input type="checkbox"/>	<input type="checkbox"/>	History of current heavy menses
<input type="checkbox"/>	<input type="checkbox"/>	Possibility of current pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Last menstrual period date

Have you ever had a colonoscopy? Yes No (please circle) If so, when? \_\_\_\_\_ why? \_\_\_\_\_

Please use the space below to describe any of the problems checked above and/or any other medical problems  
THIS IS VERY IMPORTANT.

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## Notice of Privacy Practices for the Office of Robert A. Frisenda M.D.

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.*

*Please print and sign the last page and bring it to the office.*

At the Office of Robert A. Frisenda M.D., we believe that individuals have a right to adequate notice of our policies, procedures and practices with respect to uses and disclosures of protected health information. Robert A. Frisenda M.D. is required by law

to maintain the privacy of your health information and to provide you with a notice of our legal duties and privacy practices. We are required to and will abide by the terms in the Notice of Privacy Practices in effect at the time it is provided to you. You have the right to request a paper copy of this Notice of Privacy Practices even if we have provided a copy to you electronically by e-mail.

Robert A. Frisenda M.D. will not use or disclose your individually identifiable or protected health information other than to carry out health care treatment, payment,

and/or operations for you, or as required by law. An example of treatment is a visit to our office for the purpose of diagnosis or care of a health issue wherein doctors, nurses, laboratory technicians, medical students and others will share the information about you in the course of your treatment. Payment includes sharing protected health information with an insurer or a third party that may be responsible for collecting payment from a health plan. Healthcare operations means sharing protected health information for the purpose of quality review.

Robert A. Frisenda M.D. will use and disclose protected health information to business associates in the course of providing treatment, securing payment for such treatment, and/or to facilitate health care operations of our practice, to facilitate the requirements of our business associates' contracts, and to comply with requests from other covered entities to carry out treatment, payment or health care operations.

Except for the purposes described above, Robert A. Frisenda M.D. will only use or disclose protected health information with your express written authorization and you may revoke the authorization at any time in writing. The revocation will apply only to

future uses and disclosures. Any information Robert A. Frisenda M.D. provides to a third party other than to our business associates or other health care providers with a treatment relationship to you will be de-identified or stripped of any and all personal data which could be used to identify a specific individual.

Robert A. Frisenda M.D. may contact you to provide appointment reminders or to provide you with information about alternative treatments or other health-care services we provide. We may also contact you to raise funds. When receiving communications from us, you may request that we communicate with you at an alternate location or by alternate means and we will make every effort to accommodate your request.

You may request that certain uses and disclosures of your protected health information be

restricted. To do so, you must provide the request in writing using the Request for Restriction on Use or Disclosure form available from our office. Robert A. Frisenda M.D. will determine if the information constitutes required information to carry out treatment, payment or health care operations. If, in our sole opinion, your request does not involve information that is required by us to carry out treatment, payment or health care operations, we will accept your request for restrictions and will notify you if your request will be honored within 30 days or as required by law.

With respect to your protected health information, you have the right to request and receive the following from Robert A. Frisenda M.D.:

- **Inspection and copying**—You may request a report containing your health information that has been collected by Robert A. Frisenda M.D. for you to inspect or copy. Such requests will be honored within 30 days or as required by law, and you will be notified in writing of Robert A. Frisenda M.D.'s receipt of the request and the date upon which the information will be available to you.
- **Amendment or correction**—You may request that we amend or correct your health information that has been collected by Robert A. Frisenda M.D.. Upon agreement by your health care provider, requests to amend health information will be honored within 30 days or as required by law, and you will be notified in writing of Robert A. Frisenda M.D.'s action taken.
- **Accounting of the disclosures**—You may request that we supply you with a listing of the disclosures of your protected health information which have been made by Robert A. Frisenda M.D. except those made for treatment, payment or health care operations, those required by the Final Privacy Rule or made pursuant to other law, and those made pursuant to your explicit authorization. Such requests will be honored within 30 days or as required by law, and you will be notified in writing of the date on which the accounting will be available to you. At a minimum, the accounting of disclosures will include the following information:
  - Date of each disclosure
  - Name and address of the organization of person who received the protected health information

Robert A. Frisenda M.D. has also required in our business associate contracts that they offer a means to provide such a listing for you. If you believe that your privacy rights have been violated or if you request additional information, you may send questions or complaints about this notice or Robert A. Frisenda M.D.'s privacy practices to us and/or to the Secretary of the Department of Health and Human Services (HHS) at 200 Independence Ave. SW, Washington, DC 20201. Such communication with Robert A.

Frisenda M.D. should be directed to: Chief Privacy Officer, Robert A. Frisenda M.D., 52 Hooker Ave., Poughkeepsie, N.Y. 12601 or call 845-471-5115. Robert A. Frisenda M.D. will not retaliate against you for filing a complaint with the Secretary of HHS. Robert A. Frisenda M.D. reserves the right to revise this Notice of Privacy Practices at any time without prior notification. You may request a copy of the revised notice and we will provide it to you. This Notice of Privacy Practices is effective as of 4/14/03

**Acknowledgment Form for the Notice of Privacy Practices**

Robert A. Frisenda M.D., 52 Hooker Ave., Poughkeepsie, N.Y. 845-471-5115

BY FEDERAL LAW, WE ARE REQUIRED TO PROVIDE YOU WITH OUR NOTICE OF PRIVACY PRACTICES (LOCATED ABOVE AND ONLY SUMMARIZED BELOW). THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE NOTICE IS TWO (2) PAGES LONG.

Summary:

As a patient, you have the following rights:

- 1 .The right to inspect and copy you information;
- 2.The right to request corrections to your information;
- 3.The right to request that your information be restricted;
4. The right to request confidential communication;
5. The right to a report of disclosures of your information;
6. The right to a paper copy of the Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

**Acknowledgment of Notice of Privacy Practices**

“I hereby acknowledge that I have received a copy of this practice’s NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact Robert A. Frisenda M.D. at 845-471-5115.”

“I further understand that Robert A. Frisenda M.D will offer me updates to the **Notice of Privacy Practices** should it be amended, modified, or changed in any way. I, the undersigned, acknowledge that I have reviewed and understand the **Notice of Privacy Practices** . All of my questions have been answered.”

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Representative Name (please sign)

Print Name: \_\_\_\_\_

Patient or Representative Name (please print)

Patient refused to sign

Patient was unable to sign

Reason: \_\_\_\_\_