Park Avenue Medical, LLC
Anace Said, MD
Ursula Hoxie, APRN
Juanita Dee, APRN

Please complete the enclosed questionnaire regarding your past and present health history as well as any updates to your current health status.
Please bring the following items with you to your first appointment:

- Insurance cards
- Driver's License
- Completed health questionnaire
- Past medical records or list of names and addresses of previous doctors
- List of current medications including herbal or natural supplements

We welcome you to our practice, and we look forward to a mutually rewarding relationship with you.

Date:	**Referred by:**
Name:	**SS#**
DOB:	**Sex: Male or Female** **Sexual Pref: Straight, Lesbian/Gay, Bisexual**
Address: **City:** **State & Zip:**	**Work:** **Cell:** **Home:**
Email address:	
Primary Insurance: **Policy #:** **If under spouse, need DOB:**	**Secondary Insurance:** **Policy #:** **If under spouse, need DOB:**
Subscriber's name and DOB	**Address:** **Phone:** **State & Zip:**
Emergency Contact:	**Relationship:**
Address: **City:** **State & Zip:**	**Home phone:** **Work:** **Cell:**
Preferred Pharmacy:	**Address:**

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Patient Name: _____ DOB: _____

Please initial the following, if not authorizing please answer "No"

_____ I authorize the release of my personal medical information from my other physician's medical and diagnostic facilities, hospitals, and health care provider to Park Avenue Medical, LLC. This information may consist of diagnostic information, evaluations, assessments, office notes, and treatment plans. It is my understanding that this information is to be used for the purpose of diagnosis, treatment, and coordination of my care.

_____ I authorize the release of my personal medical information from Park Avenue Medical, LLC to other physicians, Health Care providers and insurers. This information may consist of diagnostic information, evaluations, assessments, office notes, and treatment plans. It also may consist of any information concerning the treatment of drug abuse, drug related conditions, alcoholism, psychiatric or psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), and/or tests for antibodies to the AIDS virus (HIV) or anything related to the above, unless otherwise specified by myself not to be released. It is my understanding that this information is to be used for the purpose of diagnosis, treatment, and coordination of care with other physicians and medical professionals for the completion and payment of insurance claims and to obtain prescribed durable medical equipment or medications.

_____ I authorize Park Avenue Medical, LLC staff to leave voice messages on my home or cell phone regarding appointments, test results, or general information

_____ I authorize Park Avenue Medical, LLC to obtain an external listing of my current and previous medications for documentation in my electronic health record.

In addition, I authorize the release of information to the following persons or groups: Family members, attorneys, schools, etc.

Name: _____ Relationship: _____

Patient Signature/Legal Guardian: _____ Date: _____

May we have the following information? Please circle "Y" (Yes), or "N" (No).

Discharge Summary: Y N

MD Office Notes: Y N

Radiology/Mammograms: Y N

Laboratory/Pathology: Y N

Cardiology Reports: Y N

Other:

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Medical Health Questionnaire

Patient Name: Age: Date of Birth

Main Complaint:

List all current medications:

List all over-the-counter medicines, vitamins, and food supplements that you take below:

Medication Allergies: Type of Reaction:

Food Allergies: Type of Reaction:

Seasonal allergies: Sensitivities:

List surgeries you have had (include year):

Physicians you have seen in the past:

Please circle and include the duration since you've had any of the following:

High Blood Pressure **Diabetes** **Asthma** **Stroke**

Heart Attack(s)	**Migraine**	**Recurrent Fever**	**Rheumatic Disease**
Arthritis	**Autoimmune Disease**	**Cancer**	**Substance abuse**
Depression and Anxiety	**Back pain**	**Thyroid disease**	**Alcoholism**
Congenital heart defect	**Hepatitis**	**HIV**	**Seizures**

Family History:

Who in your family has/had any of the following (circle if cause of death and write age of death):

Heart Disease:	**Any Genetic Disorder:**	**Stomach Problems:**
Diabetes:	**Cancer:**	**High Blood Pressure:**
Thyroid Disease:	**Alcoholism:**	**Tuberculosis:**
Mental Illness:	**Arthritis:**	**Allergies:**
Glaucoma:	**Asthma:**	
Other Family History:		

When was your last…

Tetanus Shot:	Flu Shot:	TB Test:
Pneumonia Shot:	Hepatitis Vaccine:	Varicella/Shingles
Any Blood Work:	EKG:	HIV Test:
Colonoscopy/Sigmoidoscopy:	Chest X-Ray	

Social History:

Who you live with:

What is your Occupation:

Where you have worked/are working:

Highest Education Level:

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Weight: Desired Weight: Heaviest weight:

Do/did you exercise? How much?

Do/did you smoke? How much (Packs per day)? Year you quit:

Do/did you drink alcohol? What type? How much a day?

Previous/current problem with alcohol? AA?

Have you used any of the following in the past year (Circle)?

Caffeine Nutrasweet Marijuana Cocaine Chewing Tobacco Diet Pills

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In the past *30 days* have you been troubled with any of the following? (Check if yes, leave blank for no)

General: • Fever/sweats • Fatigue • Loss of appetite • Change in weight	**Neuro:** • Severe Headaches/Migraines • Numbness in hands and feet • Tremors • Head injury • Problems with memory
Heart: • Chest pain/angina with or without exercise • Heart racing • Irregular heartbeat • Palpitations • Swelling of feet, ankles or hands • Murmur	**Lungs:** • Frequent cough • Asthma • Shortness of breath • Coughing up blood • Wheezing • Frequent pneumonia
Eyes: • Problems with vision • Wears eyeglasses/contact lenses • Itchy/Watery eyes • Blurred or double vision • Glaucoma • Frequent eye infections Last vision exam:_____	**Ears:** • Hearing loss • Ear aches or drainage from ears • Frequent ear infections • Ringing in your ears

Nose/Throat: • Runny nose • Nosebleeds • Frequent congestion • Difficulty swallowing • Hoarseness of voice • Sore throat • Changes in voice • Snoring	**Mouth:** • Bleeding gums • Sores in mouth • Problems with teeth Last dental appointment _____
Urinary System: • Painful urination • Poor bladder control • Frequent urination at night • Passing blood • Weak urine stream	**Skin:** • Rashes • Lesions • Ulcers • Acne
Skeleton & joints: • Pain/stiffness in joints • Muscle pain/cramps/weakness • Swelling in joints • Back pain/injury	**Gastrointestinal:** • Change in bowel habits • Constipation • Diarrhea • Nausea/Vomiting • Rectal bleeding/blood in stool • Abdominal pain

	• Heartburn
Psychiatry: • Anxiety • Depression • Suicidal thoughts • Attempted suicide • Trouble falling or staying asleep • Desire psychiatric help • Problems with sexual relations	**For Women Only:** • Regular periods • Irregular periods • Bleeding between periods • Birth control pills/patches Date of last period: _____ Length of time between periods: _____ How many days do you flow for? _____ Date of last pap smear: _____ Date of last mammogram: _____ Number of pregnancies: _____ Number of living children: _____ Miscarriages: _____
For Men Only: • Sore penis • Painful scrotum • Vasectomy • Instrument passed through bladder • Discharge from penis • Problem with sexual function • Problem having children	

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Signature: **Date:**

Over the past 2 weeks, how often have you been bothered by any of the following problems	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add totals Together = _____

10. If you checked off any problems, how difficult have those problems made it for you to Does your work, take care of things at home, or get along with other people?

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Patient HIPPA & CONSENT Form

I understand that, under the Health Portability & Accountability Act of 1996 (HIPAA), I have the rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment facility and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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NO CALL NO SHOW POLICY

PAYMENT POLICY

We, at Park Avenue Medical LLC, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: (203)309-0070

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at Park Avenue Medical LLC and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. Park Avenue Medical LLC will assist you to reschedule this appointment if needed.

5. If you have 2 "No-Show/Missed" appointments, you will receive a warning letter from our office and will be assessed a $50.00 no show fee and $75.00 no show fee for Saturday appointments.

6. If you have 4 "No-Show/Missed" appointments within a one-year time, you will receive notification that you have been dismissed from the practice.

***You will be notified by letter of the dismissal**

I have read and understand Park Avenue Medical LLC, No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Park Avenue Medical LLC appropriately if I have difficulty keeping my scheduled appointments.

_____ _____

Patient Name **Date of Birth** **Date**

_____ _____

Patient Signature or Parent/Guardian if minor **Relationship**

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INSURANCE DEDUCTIBLE POLICY

To Our Patients,

Please take note that we are forced to change our billing policies.

We do accept insurance assignments for your health, but many of the commercial insurance plans have a high deductible causing a large balance on your account. In order to increase our efficiency, we will require a credit/debit card at the time of check-in, to cover those high deductibles.

The information will be held in a secure area until what your balance is. It usually takes between 2-3 weeks before we receive an insurance explanation of benefits (EOB). Once received, we will call you for your permission to use your credit or debit card on file. If you are not home, we will leave a message, if we do not hear from you within 2 days, we will charge your card for the balance and send you a copy of the receipt and EOB.

Payment in this manor will be an advantage to you and us. You will no longer have to mail in payment or call in your credit card information and for us it will save us from sending out a bill. We will still collect any copays at the time of your visit.

Thank you for your cooperation.

Patient Name: _____

Signature: _____

Relationship to patient: _____

Date: _____

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Consent to Leave Message

Patient Name: _____ D.O.B: ___/___/____

I give permission to leave messages regarding my medical or mental health on:

(Check all that apply) ☐ Mobile Voice Mail

□ Home Voicemail or Answering Machine

□ I do not give my permission to leave a message

I give permission to receive text messages on my mobile phone regarding:

(Check all that apply) □ Appointment dates and times

□ Missed appointments

□ I do not give permission to receive text messages

I Give permission to leave a message about my appointments with any person who may answer the telephone.

(Check all that apply) ☐ My mobile phone

□ My home phones

□ My work phones

□ I do not give permission to leave a message with who may answer the telephone

_____ ____/____/____

Patient Signature **Date**