



**New Patient/Update Intake Forms**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
Social Sec#: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: S M D Sep  
Address: \_\_\_\_\_ Apt#: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Please enter your email address to allow us to contact you  
Primary Care Physician: (Name, Address, Tel) \_\_\_\_\_ Age: \_\_\_\_\_  
Pharmacy: (Name, Address, Tel) \_\_\_\_\_

**EMPLOYER INFORMATION:**

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_

**EMERGENCY CONTACT:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
Relationship: \_\_\_\_\_ Address: \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

*Is the injury work related or a car accident?    \_\_\_ Yes    \_\_\_ No*  
*If yes, please circle one of the following:    Work Related    Car Accident*

**INSURANCE INFORMATION**

Health Insurance Carrier: \_\_\_\_\_ (Receptionist will copy your card)  
Insured's Information if not the same as the patient:  
Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SS#: \_\_\_\_\_  
Secondary Insurance Carrier: \_\_\_\_\_ (Receptionist will copy your card)  
Insured's Information if not the same as the patient:  
Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SS#: \_\_\_\_\_



**Please tell us how you heard about us:**

I am a Previous Patient

Referring Physician

Please Specify \_\_\_\_\_

Primary Physician

Please Specify \_\_\_\_\_

Internet

Please Specify \_\_\_\_\_

Family/Friend

Please Specify \_\_\_\_\_

Insurance

Please Specify \_\_\_\_\_

Other

Please Specify \_\_\_\_\_

NYC Triathlon Expo

What is the reason for today's visit? (Include Right or Left) \_\_\_\_\_

**REVIEW OF SYMPTOMS:**

<u>Please circle all that apply:</u>	Circle	If Yes Date	<u>Please circle all that apply:</u>	Circle	If Yes Date
<b>Constitutional</b> e.g. Fever, weight loss, malaise	YES		<b>Musculoskeletal</b> e.g. fracture, sprains, stiffness	YES	
	NO			NO	
<b>Eyes</b> e.g. Blurring, double vision, glasses	YES		<b>Skin/Breast</b> e.g. Rashes, lesions, scars, masses	YES	
	NO			NO	
<b>Ear, Nose, Throat</b> e.g. Deafness, sinusitis, vertigo	YES		<b>Neurological</b> e.g. Seizures, balance, memory, stroke	YES	
	NO			NO	
<b>Cardiovascular</b> e.g. chest pain, palpitations, high blood pressure	YES		<b>Psychiatric</b> e.g. Depression, sleep disturbance, hallucination	YES	
	NO			NO	
<b>Respiratory</b> e.g. Shortness of breath, cough, asthma	YES		<b>Endocrine</b> e.g. increased urinat ion, obesity, growth or hair changes	YES	
	NO			NO	
<b>Gastrointestinal</b> e.g. appetite, abdominal pain, constipation, weight change	YES		<b>Hematologic/Lymphatic</b> e.g. Bleeding tendency, anemia, lymph node pain or enlargement	YES	
	NO			NO	
<b>Genitourinary</b> e.g. Hesitancy, incontinence, pregnancies, menstrual problems	YES		<b>Allergic/Immunologic</b> e.g. Allergies, dermatitis, eczema	YES	
	NO			NO	

Pt. Height: \_\_\_\_\_ Pt. Weight: \_\_\_\_\_ Lbs.

Medical Conditions: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Family Medical History: \_\_\_\_\_

I certify that the above is correct and complete to the best of my knowledge.

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



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

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

If you would please take a moment to answer the following questions that we are now required by law to retrieve from you.

**Language:** English Other: \_\_\_\_\_

**Ethnicity:** Hispanic or Latino Not  
Hispanic  
Unknown

**Race:** American Indian  
Asian  
African American  
White

**Smoker:** Current Every Day  
Current Some Day  
Current Status Unknown  
Former Smoker  
Never Smoker  
Unknown if ever smoked

Pacific Islander  
Other: \_\_\_\_\_

Did you have a drink containing alcohol in the past year?

Yes

No

If 'Yes': How often did you have a drink containing alcohol in the past year?

Never

2 to 4 times a month

4 or more times a week

Monthly or less

2 to 3 times a week

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?

1 to 2 drinks

5 to 6 drinks

10 or more drinks

3 to 4 drinks

7 to 9 drinks

If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?

Never

Weekly

Less than monthly

Daily or Almost Daily

Monthly

In the past year have you had :

No falls

Two or more falls with injury

One fall without injury  
fall with injury

Two or more falls without injury

One



## Financial Policy

Thank you for choosing MOSM as your health care provider. Our practice is committed to delivering the best treatment possible for each of our patients. Your clear understanding of our financial policy is important to our professional relationship, and allows us to concentrate on patient care.

We must emphasize that as medical care providers; our relationship is with you, the patient, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges from the date of service is rendered are your responsibility. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract .

If the physician participates with your managed care medical insurance, please remember your co-payment is due at the time of service. This is a requirement of your insurance company. Please remember to have all necessary referrals completed prior to your appointment . If you insurance requires prior authorization or referral for any of your visits or treatment here, and if this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred or your visit can be rescheduled.

If we do not participate with your insurance company, payment for office visits is due at the time of service. However, we will bill surgical procedures to this insurance for you as a courtesy. Please be aware that you will continue to receive statements from us until your account is paid in full. This will alert you that the insurance company has not yet sent payment to us on your behalf. Your insurance company may send the payment to you, the insured, not the physician. It is your responsibility to forward both the payment and the accompanying explanation of benefits to our office. This will allow our billing office to post accurate payments and reconcile your account.

### **Canceled Appointments**

It is important that you keep your scheduled appointments. If you are unable to do this, please call our office at least 24 hours in advance so that another patient can be accommodated in that time slot. If you do not show for a scheduled appointment, or cancel less than 24 hours in advance, you will be charged \$50.00.

### **Dependent Children**

The responsibility of payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of the practice.

### **Workers Compensation / No Fault**

Any charges incurred for this treatment are ultimately the responsibility of the patient. Payment from the patient will be expected until the practice is provided with all the information necessary to submit a claim. We realize that temporary financial problems may affect timely payment of your account . If such problems do arise, we encourage you to contact our billing office promptly for assistance in the management of your account. If you have any questions or need any additional information regarding our financial policy, please do not hesitate to call our billing office at (212) 289-0700.

### **Payment**

I hereby authorize and instruct the insurance company(s) noted to pay authorized benefits on my behalf to MOSM. This payment will not exceed my current indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment amount. I also authorize the release of any medical information required to process payment claims.

I have read and understand the above financial policy:

Patient Name (Print): \_\_\_\_\_

Parent/Guardian Name (Print): \_\_\_\_\_

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

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



### **Use and Disclosure of Your Protected Health Information**

Your protected health information will be used by MOSM or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

### **Notice of Privacy Practices**

You should review the Notice of Privacy Practices for more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

### **Requesting a restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your protected health information. MOSM may or may not agree to restrict the use or disclosure of your protected health information. If MOSM agrees to your request, the restrictions will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal policy standards.

### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing, any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

### **Reservation of Rights to Change Privacy Practices**

MOSM reserves the right to modify the privacy practices outlined in the notice.

### **Signature**

I have reviewed this consent form and received a copy of Notice of Privacy Practices. I give my permission to MOSM to use and disclose my health information in accordance with it. Additionally, I agree that MOSM may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Patient's Name {Print}: \_\_\_\_\_ Signature: \_\_\_\_\_

Signature of Patient Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

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



**Patient Request for Confidential Communication**

Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Patient Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ SocialSec#: \_\_\_\_\_

MOSM may contact you by telephone at your home, work or cell unless you instruct us otherwise.

**Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obliged to honor it, except if any emergency arises.**

I wish to be contacted as follows {check all that apply}

via Email: \_\_\_\_\_ **We may use your email to contact you.**

At my home telephone number (\_\_\_\_) \_\_\_\_\_

Leave me a message with a call back number only

At my work telephone number (\_\_\_\_) \_\_\_\_\_

Leave me a message with a call back number only

At my cellphone number (\_\_\_\_) \_\_\_\_\_

Leave me a message with a call back number only

Send a message reminder via text message

Other: Please specify any other person {s} allowed to contact our office on your behalf:

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

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

Patient Name: \_\_\_\_\_

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

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