KezMed Medical P.C.

Date of Appointment: _____

Patient Registration Form

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

~~Signature of Patient or Authorized Guardian~~ _____ ~~Date~~ _____

ZocDoc

Check-In by

Name:_____ Age:_____ Sex:_____ Date of Appointment: _____

Reason for Visit

What brings you to the oice today?

_____

Date symptoms started _____

Have you lost any days from work or school? ☐ Yes ☐ No

Have you ever had:

- Chest Pain or Pressure
- Shortness of Breath
- ☐ Fatigue
- ☐ Dizziness
- ☐ Discomfort in Shoulder or Jaw
- Fainting
- Palpitations
- ☐ Loss of Consciousness
- ☐ Leg / Calf Pain When Walking
- ☐ Swelling in Legs
- ☐ Chest Discomfort When Exercising
- ☐ Shortness of Breath While Lying Flat

Medications

What medications are you currently taking? (Include aspirin, other blood thinners, vitamins, minerals, birth control pills, hormones, herbals, supplements)

Name	Dosage	Frequency

Family History

Has anyone in your family ever had any of the following conditions?

- Alcoholism
- Aneurysm
- Anxiety
- Blood Clots
- Cardiomyopathy
- Congenital Heart Disorder
- Depression
- Diabetes
- Heart Attack
- ☐ High Blood Pressure
- High Cholesterol
- Joint Disease
- Osteoporosis
- Seizures
- Stroke
- ☐ Sudden Cardiac Death
- ☐ Thyroid Disease
- None of the Above
- Not Sure

Details: _____

Allergies

Are you allergic to any of the following?

- ACE Inhibitors
- Adhesive Tape
- Anesthetics
- ☐ Aspirin
- Codeine
- Iodine (including contrast dye)
- Latex
- NSAIDs (Ibuprofen, Naprosyn, Advil)
- Penicillin
- Seizure Medicines
- Sulfa

Details/Reactions: _____

Past Medical History

Have you ever had any of the following?

- ☐ Acid Relux / GERD
- ☐ AIDS / HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Artiicial Valve
- ☐ Asthma
- Atrial Fibrillation
- Autoimmune Deiciency
- Back Problems
- Bleeding Disorder
- ☐ Blood Clot
- ☐ Blood Transfusion
- ☐ Cancer Type(s):_____
- ☐ Cardiac Ablation
- Cardiac Bypass Operation
- Cardiomyopathy
- ☐ Carotid Artery Surgery
- Chemotherapy
- Congenital Heart Disorder
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Deibrillator
- ☐ Depression
- ☐ Diabetes — Type I
- ☐ Diabetes — Type II
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Erectile Dysfunction
- ☐ Glaucoma
- Gout
- Heart Valve Problem Type(s):_____
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- Lupus
- Migraines
- ☐ Obesity Surgery
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peptic Ulcer
- ☐ Pericarditis
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia
- ☐ Radiation Therapy
- ☐ Restrictive Lung Disease
- ☐ Rheumatic Fever
- Skin Disorder
- Sleep Apnea
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- Tuberculosis
- Other: _____

Women Only

Number of Pregnancies: _____

Number of Miscarriages: _____

Number of Abortions: _____

Number of Living Children: _____

Birth Control: ☐ Yes ☐ No If yes, type: _____

Date of Last Period: _____

Hospitalizations & Surgeries

Reason	Date

Name:_____ Age:_____ Sex:_____ Date of Appointment: _____

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use chewing tobacco?

☐ Yes ☐ No

Are you exposed to second hand smoke?

☐ Yes ☐ No

Do you use recreational drugs?

☐ Yes ☐ No type(s)? _____

How much alcohol do you drink per week?

drinks/week _____

How much cafeine do you drink per day?

drinks/day _____

Are you sexually active?

☐ Yes ☐ No

Do you monitor your glucose?

☐ Yes ☐ No

Are you restricting your diet?

☐ Yes ☐ No

☐ Calorie Counting ☐ Low Carb ☐ Mediterranean ☐ Low Fat

☐ Low Salt ☐ Other: _____

How often do you exercise?

times/week _____

Do you have an advanced directive (i.e. living will)?

☐ Yes ☐ No

Do you have health care proxy?

☐ Yes ☐ No

Patient's Hobbies:

Review of Systems

General

☐ Excessive Thirst
☐ Fever
☐ Heat or Cold Sensitivity
☐ Night Sweats
☐ Weight Gain
☐ Weight Loss

Eye

☐ Blurry Vision
☐ Bulging Eyes
☐ Double Vision
☐ Visual Loss

Gastrointestinal

☐ Abdominal Discomfort
☐ Constipation
Diarrhea
Heartburn
☐ Nausea
☐ Vomiting

Musculoskeletal

☐ Back Pain
☐ Fracture
☐ Joint Stifness
☐ Joint Pain
☐ Muscle Cramping

Neuro/Psychological

☐ Anxiety
☐ Burning in Feet
Depression
Headaches
☐ Memory Loss
Numbness
Seizures
Sleeping Problems
☐ Suicidal Attempts or Thoughts
☐ Tremor

Respiratory

☐ Coughing
☐ Coughing up Blood
☐ Wheezing

Ear, Nose & Throat

☐ Hoarseness / Change in Voice
☐ Sinus Congestion

Skin

☐ Easy Bruising
☐ Excessive Dry Skin
Excessive Hair Growth
New Stretch Marks
☐ Skin Discoloration

Urinary

☐ Diiculty Urinating
☐ Decreased Libido
☐ Urinating in Middle of Night

Health Exams and Procedures:

	Date of most recent exam/procedure		Date of most recent exam/procedure
☐ Angiogram / Cardiac Catheterization		☐ Eye Exam	
☐ Cardiac CT		☐ Heart Monitor	
☐ Cardiac Stress Test		☐ Hemoglobin A1C	
☐ Cholesterol		☐ Ultrasound for Abdominal Aneurysm	
☐ Echocardiogram		☐ Ultrasound/Doppler of Carotid Arteries	
☐ EKG			

KezMed Medical PC
1963 Williamsbridge Road, Bronx, NY 10461
129 Wadsworth Avenue #4, New York, NY 10033
Phone: 646 530 8447

ASSIGNMENT OF BENEFITS

I authorize and direct my insurer or payor to pay directly to Anna Kezerashvili, M.D. and KezMed Medical P.C. (together, "Provider") any or all benefits, that would otherwise be payable to me (or the patient, if signed by a responsible party), up to the amount of my bill, accruing to me in connection with my treatment by Provider.

I request that payment of authorized Medicare, Medigap or other health insurance policy benefits for services furnished to me by Provider be made on my behalf to Provider. In the event that payments are made to Provider and me as joint payees, I agree to cooperate with Provider to ensure that Provider receives all amounts due to Provider.

I hereby authorize Provider to pursue any means necessary to collect all charges on my account including follow up calls, appeals, arbitration, and civil suit, if allowable under law. In the event that Provider elects to bring an appeal, lawsuit or petition for arbitration against the insurance carrier, I hereby assign to it my rights, title, and interest under any insurance policy under which I am entitled to proceed for benefits, if allowable under law. This assignment shall allow an attorney of its choosing to bring suit or submit to arbitration its claim of any unpaid or underpaid bills for treatment rendered by Provider.

Print name of Patient or Guarantor	*Signature*	*Date*

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

PATIENT NAME: _____ DOB: _____

APPOINTMENT REMINDER AUTHORIZATION FORM

Please indicate below how you would like to receive reminders for your appointments:

EMAIL

I authorize KezMed Medical PC to send Appointment Reminders electronically via Email to the following email address.

EMAIL ADDRESS (please print clearly):

_____

TEXT MESSAGE

I authorize KezMed Medical PC to send Appointment Reminders electronically via text message to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for the patient/mobile phone number:

MOBILE#:

_____

Patient Signature: _____ Date: _____

OR

Parent/Legal Guardian Signature: _____ Date: _____

KezMed Medical P.C.
1963 Williamsbridge Rd Bronx, NY 10461
Phone: 646-530-8447 Fax: 718-577-5462

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of Kezmed Medical PC Notice of Privacy Practices. I have therefore been advised of how health information about me may be used and disclosed by KezMed Medical PC, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

Signature of Patient or Personal Representative _____

Date: _____

Print Name of Patient or Personal Representative _____

Date: _____