Kings Park Family Medicine
Weymin G Hago MD
Elana Coscetta RPA-C
93 Main St. Suite A Kings Park, NY 11754

Name:_____ Today's Date:_____

Date of birth:_____Soc. Sec. No. _____ Sex: M__ F__

Address:_____ Home Tel. No._____

City:_____ State: _____Zip:_____ Cell Phone: _____

Emergency Contact: _____ Tel No. _____

Relationship To Patient_____

Employer Name: _____ Tel. No._____

Spouse / Parent Name: _____ Tel No._____

Spouse / Parent Employer Name: _____ Tel No. _____

Email Address _____

PRIMARY INSURANCE

Primary Card Holder_____ Relationship:_____

Date of Birth: _____ Soc. Sec. No. _____

Insurance Name: _____ Tel No. _____

Address: _____

ID Number: _____ Group Number:_____

SUPPLEMENTAL INSURANCE

Subscriber Name: _____ Relationship: _____

Insurance Name: _____ Address: _____

ID Number: _____ Group Number: _____

I have received and understand Kings Park Family Medicine Notice of Privacy Practices, and all of my questions have been answered to my satisfaction

Signature: _____ Date: _____

I authorize Kings Park Family Medicine to submit claims for services rendered on my behalf and request that payment for services be made directly to Kings Park Family Medicine

Signature: _____ Date: _____

I authorize the release of medical information about me to the health care financing administration, insurance company and other health care providers.

Signature : _____ Date: _____

KINGS PARK FAMILY MEDICINE

Weymin G Hago MD
Elana Coscetta RPA-C
93 Main Street, Suite A
Kings Park, NY 11754
Phone: 631-292- 2725
Fax: 631-292-2727

FAMILY AND FRIENDS CONTACT FORM

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list those persons (including Family, Friends, Previous Treating Physicians, other doctors/specialists) with whom we may share your information:

_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

What is the best phone number for us to contact you? _____

What is this number? (Home, Work, Cell, Other)? _____

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence.

Is it ok for such message to include details (such as diagnosis and medication information) at this number? _____

What other ways may we contact you? Please list all that are acceptable ways to reach you.

_____

Home Phone Number: _____
Is it ok to leave a detailed message at this number in your absence? _____

Work Number: _____
Is it ok to leave a detailed message at this number in your absence ?

Cell Phone Number: _____
Is it ok to leave a detailed message at this number in your absence? _____

Other: _____
Is it ok to leave a detailed message at this number in your absence?_____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Date of Birth SSN

_____ _____
Print name Relationship

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NEW PATIENT MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N
PSA	Date:	Facility/Provider:	Abnormal Result? Y N
SKIN CANCER SCREENING	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

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FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			

Patient Name: _____ DOB: _____

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OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: ❑ Male ❑ Female		
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy		
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.): _____	How often: _____
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: _____ DOB: _____

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REVIEW OF SYSTEMS ✔ CHECK ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
☐ Activity change	☐ Chest pain	☐ Color change
☐ Appetite change	☐ Leg swelling	☐ Pallor
☐ Chills	☐ Palpitations	☐ Rash
☐ Diaphoresis	**Gastrointestinal**	☐ Wound
☐ Fatigue	☐ Abdominal distention	**ALLERGY/IMMUNO**
☐ Fever	☐ Abdominal pain	☐ Environmental allergies
☐ Unexpected weight change	☐ Anal bleeding	☐ Food allergies
HEAD, EAR, NOSE & THROAT	☐ Blood in stool	☐ Immunocompromised
☐ Congestion	☐ Constipation	**NEUROLOGICAL**
☐ Dental problem	☐ Diarrhea	☐ Dizziness
☐ Drooling	☐ Nausea	☐ Facial asymmetry
☐ Ear discharge	☐ Rectal pain	☐ Headaches
☐ Ear pain	☐ Vomiting	☐ Light-headedness
☐ Facial swelling	**ENDOCRINE**	☐ Numbness
☐ Hearing loss	☐ Cold intolerance	☐ Seizures
☐ Mouth sores	☐ Heat intolerance	☐ Speech difficulty
☐ Nosebleeds	☐ Polydipsia	☐ Syncope
☐ Postnasal drip	☐ Polyphagia	☐ Tremors
☐ Rhinorrhea	☐ Polyuria	☐ Weakness
☐ Sinus pressure	**Genitourinary**	**HEMATOLOGIC**
☐ Sneezing	☐ Difficulty urinating	☐ Adenopathy
☐ Sore throat	☐ Dysuria	☐ Bruises/bleeds easily
☐ Tinnitus	☐ Enuresis	**PSYCHIATRIC**
☐ Trouble swallowing	☐ Flank pain	☐ Agitation
☐ Voice change	☐ Frequency	☐ Behavior problem
EYES	☐ Genital sore	☐ Confusion
☐ Eye discharge	☐ Hematuria	☐ Decreased concentration
☐ Eye itching	☐ Penile discharge	☐ Dysphoric mood
☐ Eye pain	☐ Penile pain	☐ Hallucinations
☐ Eye redness	☐ Penile swelling	☐ Hyperactive
☐ Photophobia	☐ Scrotal swelling	☐ Nervous/anxious
☐ Visual disturbance	☐ Testicular pain	☐ Self-injury
RESPIRATORY	☐ Urgency	☐ Sleep disturbance
☐ Apnea	☐ Urine decreased	☐ Suicidal ideas
☐ Chest tightness	**MUSCULAR**	
☐ Choking	☐ Arthralgias	
☐ Cough	☐ Back pain	
☐ Shortness of breath	☐ Gait problems	
☐ Stridor	☐ Joint swelling	
☐ Wheezing	☐ Myalgias	
☐	☐ Neck pain	
☐	☐ Neck stiffness	

Patient Name: _____ DOB: _____

Family history questionnaire

MyRisk®
Hereditary Cancer Test

Personal information

Patient name	Date of birth	Healthcare provider	Today's date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. The following blood relatives should be considered: **parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.** For cancer sites with a '1st-degree relative' notation, only parents, siblings, and children should be considered.

Do you have personal history of:	Yes (Y) / No (N)	Which cancer?	Age at diagnosis?
Breast, ovarian, colon, rectal or pancreatic cancer at any age	☐ Yes ☐ No		
Uterine cancer at 64 or younger	☐ Yes ☐ No		

Do you have family history of:	Yes (Y) / No (N)	Maternal (M) Paternal (P)	Which relative?	Age at diagnosis?
Breast cancer at 50 or younger	☐ Yes ☐ No	☐ M ☐ P		
Two different breast cancers in one relative at any age	☐ Yes ☐ No	☐ M ☐ P		
Three breast cancers in relatives on the same side of the family at any age	☐ Yes ☐ No	☐ M ☐ P		
Ovarian cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Male breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Triple negative breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Pancreatic cancer at any age (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Metastatic or high-risk prostate cancer at any age (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Colon cancer at 49 or younger (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Uterine cancer at 49 or younger (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Three colon and/or uterine cancers on the same side of the family at any age	☐ Yes ☐ No	☐ M ☐ P		
Do you have family history of other cancers?	List them here:			
Have you or anyone in your family had genetic testing for hereditary cancer?	Who?		What gene?	Result?

Cancer risk assessment review (to be completed after discussion with your healthcare provider)

Patient signature	Date
Healthcare provider signature	Date

Office use only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No / ☐ Accepted ☐ Declined

If yes, which test? ☐ BRACAnalysis® with MyRisk® / ☐ Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with MyRisk®

☐ COLARIS® PLUS with MyRisk® / ☐ COLARIS AP® PLUS with MyRisk® / ☐ Single site testing / ☐ MyRisk® Update Test

☐ Other: _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____

Myriad genetics

www.myriad.com / Myriad Genetics, Inc., 322 North 2200 West, Salt Lake City, UT 84116

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:
Kings Park Family Medicine 93 Main Street Suite A Kings Park, NY 11754 (631) 292-2725 (631)292-2727 Fax

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.**

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MISSED APPOINTMENT & CANCELLATION POLICY

If you are unable to keep a scheduled appointment, please give 24 hours advance notice, to ensure that you will not be charged for the appointment.

If less than 24 hour notice is givenyou will be expected to pay a $30.00 No Show fee forthat appointment.

Name: _____ DOB: _____

Signature: _____

Date: _____

Witness: _____