Dedicated Medical Care

Patient Registration

Last Name _____ First Name _____ MI_____ Sex:_____

Address _____ City/State_____ Zip_____

Home Phone _____ Work# _____ Cell#_____

Email Address: _____

Date of Birth _____ Social Sec # _____

Relationship Status: Single Married /Dom. Partnership Divorced Widowed Employer_____

Emergency Contact _____ Relationship_____ Phone #_____

Primary Care Physician _____ Phone#_____ Fax#_____

Name of Referring Physician or Other Referral Source: _____

Primary Insurance _____

Print name of policy holder	Policy holder date of birth	Relationship to patient

Secondary Insurance _____

Print name of policy holder	Policy holder date of birth	Relationship to patient

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If you authorize anyone in your family, a friend, or a personal caregiver **to receive this information** please **complete this form** and return to the receptionist. I authorize the office to communicate with by email when necessary.

Please indicate if you authorize the office to leave messages on you home answering machine **Yes** **No**

____Test results ____Billing information ____Medication information

List any person who is able to receive your protected health information and the information we are able to share with them.

1. _____

____Test results ____Billing information ____Medication information

2. _____

____Test results ____Billing information ____Medication information

_____ _____

Signature **Date**

Dedicated Medical Care Policies

1. I understand that I am responsible for charges not covered by my insurance company. I agree, in the event of non-payment, to assume the costs of all interest and fees due to collection legal action. One statement will be sent to you as a courtesy. For each additional statement sent due to non-payment, a $10 billing fee will be added to your account. Payment for self-pay patients is due at the time of service.

2. I authorize my insurance carrier to release information regarding my insurance coverage to DRS Feldman and Galotto, LLC. I also authorize agents of any hospital, treatment facility or previous physicians to furnish DRS. Feldman and Galotto, LLC copies of any and all records of my medical history. I authorize the release of my medical records to any federal, state or accreditation agency. I agree to a review of my records for purpose of internal audits, research and quality assurance reviews within the office.

3. My right to payment for all procedures, tests, supplies and services including major medical benefits are hereby assigned to DRS. Feldman and Galotto, LLC. This assignment covers any and all benefits under Medicare, all government sponsored programs, private insurance companies, and other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment for services. In the event my insurance carrier does not accept assignment of benefits, or if payments are made directly to my representative, or me, I will endorse such payments to DRS. Feldman and Galotto, LLC.

4. I understand that when paying by check to DRS. Feldman and Galotto, LLC, I will be responsible for a $25 fee if a check is returned. This does not include any other fees applied by your bank.

5. I understand that I am responsible for any fees not covered by my insurance. In the event that my account becomes delinquent and is forwarded to an attorney or agency for collection, I am responsible for the fees including court costs.

6. I acknowledge receipt of the Notice of Privacy Policies provided by DRS. Feldman and Galotto, LLC. I am responsible for reviewing all information.

7. I authorize DRS. Feldman and Galotto, LLC to contact me for the following reasons:
   - Permission to call me at home, office, or mobile to confirm or reschedule an appointment, to provide me with test results, or to return my message(s).
   - Permission to leave appointment reminders or appointment cancellation notifications on an answering machine, voice mail, with a family member, secretary, or household employee.
   - Permission to leave "your test results were normal" on an answering machine.

I understand that missed appointments and appointments canceled without 24 hours notice are subject to a $25 fee.

Name of Patient and/or Guardian (please print):_____

Signature of Patient of Guardian: _____

Date: _____

Please List the **names and dosage of all medications** you are taking (include regularly used over-the-counter medications/supplements).

_____ Please check here if you are currently taking NO medications.

Medication Name **Dosage & Directions**

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name _____ Phone_____

Street _____ City/Zip_____

Are you allergic to any of the following medications:

Allergen **REACTION**

Penicillin _____

Sulfa _____

Latex _____

IV contrast dye _____

Cipro _____

Codiene _____

Levaquin _____

Macrobid _____

Others (please list) _____

_____ check here if you are **NOT** allergic to any medications

Health Maintenance

When were last immunized for: Flu _____, Pneumonia _____,

Shingles _____, Td_____ Tdap_____ Hepatitis B _____.

When was your last pap smear? _____ Where? _____

When was your last mammogram? _____ Where? _____

When was your last Colonoscopy? _____ Where? _____

Social History

Do you smoke? _____ yes _____Not anymore _____ never smoked

How long have you smoked? _____

How many packs per day? _____

When did you quit? _____

Do you drink alcohol? _____ yes _____ not anymore _____ Never

How much do you drink per week? _____

What do you drink? _____

When did you stop drinking? _____

Do you exercise? _____ No _____Yes, if yes how often _____/week

What type of exercise? _____

What is your race? _____ White _____ Black/African American _____ Asian
_____ Hispanic or Latino _____American Indian/Alaskan Native _____ Other/Declined

What is your ethnicity? _____Hispanic or Latino _____ Not Hispanic or Latino

_____Unknown _____ Declined

Surgical History

List all of your past surgeries: _____

_____

_____

_____

Past Medical History

Have you ever been treated for any of the following medical problems?

_____ Anemia

_____ Angina

_____ Alzheimers/dementia

_____ Asthma/emphysema/COPD

_____ Atrial fibrillation

_____ Bleeding conditions

_____ Blood clots/DVT/pulmonary embolus

_____ Cancer (Please list) _____

_____

_____

_____

_____ Cataracts

_____ Congestive Heart Failure

_____ Depression

_____ Diabetes

_____ Gastric reflux

_____ Gastrointestinal bleeding

_____ Glaucoma

_____ Heart Attack

_____ Hepatitis

_____ High blood pressure

_____ High Cholesterol

_____ HIV/AIDS

_____ Migraine

_____ Osteoporosis

_____ Osteopenia

_____ Parkinson's

_____ Seizure disorder

_____ Sleep Apnea

_____ Thyroid disease

_____ Tuberculosis

_____ Urinary Infections

Others (please list) _____

_____

_____

_____

_____

_____

_____

Family History

Father: _____Living _____ Deceased (If deceased what year_____, Age _____)

Mother: _____Living _____ Deceased (If deceased what year_____, Age _____)

Siblings: Please indicate brother or sister and complete the information for each sibling.

Brother/Sister: _____Living _____ Deceased (If deceased what year_____, Age _____)

Brother/Sister: _____Living _____ Deceased (If deceased what year_____, Age _____)

Brother/Sister: _____Living _____ Deceased (If deceased what year_____, Age _____)

Brother/Sister: _____Living _____ Deceased (If deceased what year_____, Age _____)

Brother/Sister: _____Living _____ Deceased (If deceased what year_____, Age _____)

Do you have any relatives with any of the following medical conditions?

Please indicate the appropriate family member(s) for each

Condition	Mother	Father	Sister	Brother
Diabetes				
Angina				
migraine				
seizures				
Alcoholism				
Heart attack				
High cholesterol				
hepatitis				
Breast cancer				
tuberculosis				
High blood pressure				
Asthma				
Osteoporosis				
Kidney disease				
depression				
Cancer (where)				
List any others				

PATIENT NAME: _____

REVIEW OF SYSTEMS

Do you have any problems related to the following? Please check **YES** or **NO** for each.

CONSTITUTIONAL	YES	NO
Fever	☐	☐
Fatigue	☐	☐
Weight loss	☐	☐
Weight gain	☐	☐

EYES	YES	NO
Blurry vision	☐	☐
Double Vision	☐	☐

EARS, NOSE, MOUTH, THROAT	YES	NO
Hearing loss	☐	☐
Nasal stuffiness	☐	☐
Sore throat	☐	☐

CARDIOVASCULAR	YES	NO
Chest pains	☐	☐
Swollen ankles	☐	☐
Palpitations	☐	☐

RESPIRATORY	YES	NO
Shortness of breath	☐	☐
Wheezing	☐	☐
Chronic cough	☐	☐

GASTROINTESTINAL	YES	NO
Abdominal pain	☐	☐
Nausea/vomiting	☐	☐
Change in bowel habits	☐	☐

MUSCOSKELETAL	YES	NO
Joint pain	☐	☐
Joint swelling	☐	☐
Muscle pain	☐	☐
Muscle cramps	☐	☐

PSYCHIATRIC	YES	NO
Anxiety	☐	☐
Depression	☐	☐
Mood swings	☐	☐
Insomnia	☐	☐

INTEGUMENTARY, SKIN	YES	NO
Rash	☐	☐
Persistent itching	☐	☐
Skin cancer history	☐	☐

NEUOROLOGICAL	YES	NO
Numbness	☐	☐
Tingling	☐	☐
Dizziness	☐	☐

HEMATOLOGIC, LYMPHATIC	YES	NO
Swollen glands	☐	☐
Abnormal bleeding	☐	☐
Bruise easily	☐	☐

UROLOGICAL	YES	NO
Frequent urination	☐	☐
Pain with urination	☐	☐
Change in urination	☐	☐
Change in urination flow/stream	☐	☐
Nocturia	☐	☐
Vaginal spotting	☐	☐
Regular menstruation	☐	☐