



Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. PLEASE PRINT CLEARLY.

Patient Name: Date of Visit:
Date of Birth: Age: Preferred Phone:
Preferred email: Social Security Number:
Address: Emergency Contact (Name and Number):
Marital Status: Spouse/Significant Other:
Employer: Occupation:
INSURANCE CARRIER: INSURANCE ID #:
Does your insurance plan require referrals for specialty visits? If YES, do you have a referral for today's visit?

Physician and Pharmacy Information
Primary Care Provider (Name/Phone/Fax Number): Preferred Pharmacy (Name/Phone/Fax Number/Address):
Referring Physician (Name/Phone/Fax Number): Other Physician to send records to (Name/Phone/Fax Number):
Specialty: Specialty:
Other Physician to send records to (Name/Phone/Fax Number): Other Physician to send records to (Name/Phone/Fax Number):
Specialty: Specialty:

Reason/s For Visit:

Medical History
Please include all medical problems even if not relevant to this visit. If no medical problems, write none.
Table with 3 columns: Current or Past Medical Problems, Dates, Reasons

Table with 3 columns: Hospitalizations/Surgeries, Dates, Reason

Table with 2 columns: Allergies (Medication, Food, Cosmetics, Etc.), Cause/Nature of Reaction

Medications/Supplements	Dosage/Frequency	Condition/Reason

Family and Social History			
Family History: Mother	Family History: Father	Family History: Siblings	Family History: Children
<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Other: _____

Do you drink alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Yes. I drink <input type="checkbox"/> wine <input type="checkbox"/> beer <input type="checkbox"/> liquor <input type="checkbox"/> I have _____ drink(s) per week <input type="checkbox"/> I used to drink but quit in _____ (year)	Do you smoke? <input type="checkbox"/> I never smoked <input type="checkbox"/> Yes. I smoke <input type="checkbox"/> cigarettes <input type="checkbox"/> cigars <input type="checkbox"/> pipes. <input type="checkbox"/> I currently smoke and I don't want to quit <input type="checkbox"/> I currently smoke but I'm ready to quit. <input type="checkbox"/> I smoke _____ pack(s) per day for _____ years <input type="checkbox"/> I used to smoke but quit in _____ (year) <input type="checkbox"/> I use chewing or smokeless tobacco	Do you use recreational drugs? <input type="checkbox"/> Never <input type="checkbox"/> No, but I have used _____ <input type="checkbox"/> Yes, I use _____
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Do you eat or drink foods containing caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you taken any aspirin, Advil, Nuprin (NSAIDs) in the last 7 days? <input type="checkbox"/> Yes (if so, what medication? _____) <input type="checkbox"/> No
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Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often and what type?
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Date of most recent colonoscopy/endoscopy:	Date of most recent flu shot:	Date of most recent pneumonia shot (age 65+):
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How did you hear about us? <input type="checkbox"/> Physician <input type="checkbox"/> Family/Friend <input type="checkbox"/> Internet <input type="checkbox"/> Health Plan <input type="checkbox"/> Advertisement <input type="checkbox"/> Referral Service <input type="checkbox"/> Weill Cornell Connect <input type="checkbox"/> Int'l Office

Communication Consent
I hereby authorize the physician and/or the staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.
<input type="checkbox"/> Home Telephone/Answering Machine <input type="checkbox"/> Work Telephone <input type="checkbox"/> Cell Phone/Voicemail <input type="checkbox"/> Email <input type="checkbox"/> Regular Mail
List of Authorized people that can received your medical information (other than medical professionals listed on page 1)
Name: _____ Relation: _____ Tel: _____ _____
Name: _____ Relation: _____ Tel: _____ _____
Name: _____ Relation: _____ Tel: _____ _____

<i>The information is accurate and complete to the best of my knowledge. I will not hold the physician or his staff responsible for any error or omission that I may have made completing this form.</i>	
Patient Signature: _____	Physician Signature: _____

Name of person completing form (if not patient):

Signature:

Today's Date:

Today's Date:

Review of Systems

Please check 'YES' or 'NO' for EACH item

Constitutional

- Normal
Y N
 Fever
 Chills
 Night sweats
 Weight loss/gain
 Sleep disturbance
 Fatigue
 Poor appetite

Eyes

- Normal
Y N
 Contact lenses or glasses
Type: _____
 Blurry vision
 Glaucoma
 Cataracts
 Retinal detachment
 Macular degeneration
 Blindness
 Redness
 Tearing
 Dryness
 Double Vision
 Discharge
 Pain

Ear

- Normal
Y N
 Hearing loss
 Hearing aids
 Wax
 Ear pain
 Ringing/noise/tinnitus
 Previous ear surgery
 Loud noise exposure

Respiratory

- Normal
Y N
 Asthma
 Emphysema/COPD
 Bronchitis
 Pneumonia
 Aspiration
 Tracheotomy
 Tuberculosis
 Coughing blood
 Shortness of breath
 Wheezing
 Cough over 3 months
 Pulmonary embolus

Nose

- Normal
Y N
 Congestion
 Mucus
 Post nasal drip
 Sinus infection
 Sinus headaches
 Nose Bleeds

Allergy

- Normal
Y N
 Sneezing
 Runny Nose
 Itchy ears, eyes, or nose
 Transplant
 Hives

Throat

- Normal
Y N
 Voice problems
 Swallowing problems
 Throat Pain
 Phlegm
 Feeling of something stuck
 Tonsil infections/problems

Sleep

- Normal
Y N
 Snoring
 Sleep Apnea
 CPAP/BiPAP/AutoPAP
 Insomnia
 Choking/Gasping
 Restless leg
 Daytime sleepiness

Gastrointestinal

- Normal
Y N
 Diarrhea
 Constipation
 Blood in stool
 Vomiting/nausea
 Ascites
 Heartburn/acid reflux
 Abdominal pain
 Ulcers
 Diverticulitis
 IBD
 Hepatitis
 Gallstones
 Pancreatitis
 Jaundice
 Cirrhosis

Endocrine

- Normal
Y N
 Diabetes
 Thyroid problems
 Autoimmune disease
Type: _____
 Immune deficiency
 Excessive thirst
 Swollen lymph nodes
 Cold/heat intolerance
 Gout

Neurologic/Neuromuscular

- Normal
Y N
 Headaches/migraines
 Encephalopathy
 Seizures
 Tremors
 Numbness
 Stroke
 Imbalance/vertigo
 Lightheaded/fainting
 Memory loss
 Unexplained weakness

Hematologic

- Normal
Y N
 Bruise easily
 Anemia
 Leukemia/Lymphoma
 Blood clots
 Bleeding disorders
 History of radiation

Oral/Dental

- Normal
Y N
 Dentures/implants
 Temporomandibular joint
 Teeth clenching/grinding
 Tongue problems
 Mouth lesions

Genitourinary

- Normal
Y N
 Frequent urination
 Prostate problems
 Urine/bladder infections
 Yeast infections
 Incontinence
 Kidney problems/stones
 Dialysis
 Transplant

Skin

- Normal
Y N
 Past skin cancer
Type: _____
 Skin biopsy
Site: _____
 Eczema
 Rash or skin sensitivity
 Abnormal skin moles
 History of skin disease
 Hair loss/growth
 Itching
 Keloid scars

Musculoskeletal

- Normal
Y N
 Neck pain
 Arthritis
 Back pain/spinal problems
 Fractures
 Muscle pain
 Swelling
 Joint/bone pain

Cardiovascular

- Normal
Y N
 Heart attack
 High blood pressure
 High cholesterol
 Stents
 Coronary artery disease
 Irregular heart beat
 Chest pains
 Leg swelling
 Pacemaker/defibrillator

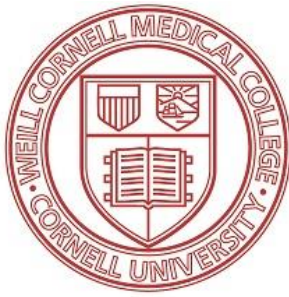
Psychiatric

- Normal
Y N
 Anxiety
 Depression
 Bi-polar
 Psychosis

Men's/Women's Health

- Normal
Y N
 Sexual problems
 Genital lesions
 Enlarged prostate (BPH)
 Abnormal discharge
 Cancer
Type: _____

Any other comments/problems/concerns:



Weill Cornell Physicians

Financial Policy

Thank you for choosing Weill Cornell Physicians for your health-care needs.

The following is our payment policy which we require you to read and sign prior to your visit(s).

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your medical insurance and/or Medicare card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or medical insurance information. Patients without medical insurance are required to pay in full at time of service.

We understand that financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. Please ask to speak to our Site Manager to discuss a satisfactory arrangement.

Participating Plans

You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance cards or proper referrals will be asked for full payment at time of service. All co-pays, deductibles and non-covered services will be collected at time of service.

Non-Participating Plans

If your provider does not participate in your insurance plan, you are responsible for payment of all charges at the time of service. We can submit the claim directly to your carrier or a claim can be mailed to you.

Payment in full is due at the time of service for all non-medically necessary services and/or cosmetic services.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment

For your convenience, the following payment methods are accepted:
Cash, personal check, Visa, MasterCard, American Express, Discover



I have read the policy, I understand and agree to it.

Patient Signature

Date

Print Name