INFORMACION DE PACIENTE

FECHA: _____

APELLIDO:_____NOMBRE:_____SEXO:_____

FECHA DE NACIMIENTO:_____CASADO: ___ SOLTERO: ___ VIUDO: ___ DIVORCIADO: ___

NUMERO DE SEGURO SOCIAL #: _____

DIRECCION: _____

CIUDAD/ESTADO: _____ ZONE POSTAL: _____

TELEFONO DE CASA: (_____)_____TELEFONO CELULAR: (_____)_____

TELEFONO DE TRADAJO: (_____)_____EMAIL: _____

EMPLEADOR: _____ DIRECCION DE EMPLEADOR: _____

CONTACTO DE EMERGENCIA: _____ RELACION: _____

NUMERO DE CONTACTO EN CASO DE EMERGENCIA: (_____)_____

NOMBRE DE DOCTOR DE CABECERA: _____

REFERIDO POR: _____

SEGURO PRIMARIO (NOMBRE):_____

NUMERO DE POLIZA PRIMARIA (ID#): _____

SEGURO SECUNDARIO (NOMBRE): _____

NUMERO DE POLIZA SENCUNDARIA (ID#): _____

FARMACIA (NOMBRE Y NUMERO DE TELEFONO) _____

AUTORIZACION, CONCENTIMIENTO Y ASIGNACION DE BENEFICIOS

DOY CONCENTIMIENTO A LA OFFICINA DEL DOCTOR NOAH SCHEINFELD PARA INCLUIR EVALUACION, DIAGNOSIS, CONSULTA Y TRATAMIENTO DE ATENCION MEDICA. DOY AUTORIZACION PARA QUE MIS BENEFICIOS DE SEGURO SEAN PAGADOS DIRECTAMENTE A LA OFFICINA DEL DOCTOR NOAH SCHEINFELD Y COMPRENDO QUE SOY RESPONSIBLE FINANCIERAMENTE POR SERVICIOS NO CUBIERTOS.

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FIRMA: _____FECHA: _____ PARENTESCO AL PACIENT (**SI MENOR**)_____

NOMBRE_____**EDAD**_____**FECHA DE NACIMIENTO** _____ **FECHA** _____
SS#_____

ALERGIA _____

RAZON POR LA VISITA _____

HISTORIAL MEDICO: HA TENIDO USTED ALGUNO DE LOS SIGUIENTES?

	YES	NO	ESPLICACION	Medications
ASMA				
DIADETES				
SALUD GENERAL				
PROBLEMAS DE VISION				
PROBLEMAS DE AUDICION				
ENFERMEDAD DEL CORAZON				
ENFISEMA O BRONQUITIS CRONICO				
PROBLEMAS ESTOMACALES				
PROBLEMAS DE RINON/VEJIGA				
ARTRITIS				
PROBLEMAS EN LA PIEL				
DOLORES DE CABEZA SEVERAS				
DEPRESION O PROBLEMAS PSICOLOGICOS				
PROBLEMAS DE TIROIDE				
PROBLEMAS DE VASOS SANGUINIOS				
ALERGIAS				
HEPATITIS				

MUJERES: ESTA USTED EMBARASADA? SI___NO____ PLANIFICANDO UN EMBARAZO? SI____NO ____ ANTI-CONCEPTIVOS? SI___NO___

HISTORIAL DE FAMILIA

MADRE : VIVA/FALLECIDA_____ EDAD____ PADRE: VIVO/FALLECIDO_____EDAD___ TIENE HIJOS: SI____ NO _____ CUANTOS_____

	Madre	Padre	PARIENTE
ALERGIAS			
ARTRITIS			
ASMA			
CANCER			
DIABETES			
ECZEMA			
DESORDEN DE FIEBRES			
ENFERMEDAD DEL CORAZON			
ALTA PRESION			
ENFERMEDAD DEL PULMON			
MALIGNO MALINOMA			
PSORIASIS			
CANCER DE LA PIEL			
TUBERCULOSIS			

VIVE SOLO/A? SI ____NO ____FUMA?SI ____NO ____FREQUENCIA: _____ TOMA ALCOHOL?SI_____ NO_____ FREQUENCIA:_____

USA DROGAS RECREATIVAS?SI ___NO ___ OCCUPACION_____ REVIEWED_____DATE_____

New Patient Consent to Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations (aka HIPAA acknowledgement) by Noah Scheinfeld MD PLLC

I, _____, understand that as part of my health care, Noah Scheinfeld, MD, PLLC, originates & maintains paper and/or electronic records describing my health history, symptoms, examination & test results, diagnoses, treatment, & any plans for future care or treatment. Your health information is both private & secure. This table outlines the uses & disclosures of information we use:

Uses and Disclosures of Health Information
• We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. • We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. • We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice on our website www.summithhc.com. You can also request a copy of our notice at any time. For more information about our policy practices, contact the person listed below.

I understand the table of Uses & Disclosures of Health Information above provides Noah Scheinfeld MD PLLC's *Notice of Information Practices* and that I have the following rights & privileges:

Individual Rights
• In most cases, you have the right to look at or obtain a copy of health information about you that we use to make decisions about you. • You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. • You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. Your first request for an "Accounting of Disclosures" will be free of charge. Subsequent requests will be granted for a $5.00 fee. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

I understand that (1) I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon (2) refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by § 164.506 of the Code of Federal Regulations (CFR) (3) Noah Scheinfeld, MD, PLLC., reserves the right to change their notice and practices and prior to implementation, in accordance with §164.520 of CFR. Should Noah Scheinfeld, MD, PLLC., change its notice, it will send a copy of any revised notice to the address I've provided (whether U.S mail or, if I agree, email) & (4) as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via fax. I wish to have the following restrictions to use or disclosure of my health information: _____
_____

I fully understand and accept / decline the terms of this consent.

_____ _____ 2010

PATIENT'S SIGNATURE **DATE**

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

Noah Scheinfeld MD PLLC 150 West 55th Street NYC, NY 10019 (212) 991-6490

AUTORIZACION, CONCENTIMIENTO Y ASIGNACION DE BENEFICIOS

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FECHA: _____2010 FIRMA_____

PACIENTE/PARIENTE_____