PATIENT INFORMATION
(PLEASE PRINT CLEARLY)

Today's Date:

Last Name: First Name: Middle Init. ____

Address: _________________________________Zip: ____________City & State: _________________________

Gender: Date of Birth:

Home Phone: ____________________Cell Phone: ____________________ Other Phone: ____________________

We now have patient portal where you can send messages directly to your doctor, request medication refills, view your medical records and receive your test result, please provide your email address where we should send your log on information.

Your Personal E-Mail Address: ____

Race: (Circle one) American Indian Asian Black Native Hawaiian White Decline to answer

Ethnicity: (Circle one) Hispanic Origin NON-Hispanic Origin Decline to answer

Preferred Language: (Circle one) English Other: _________________ Decline to answer

Primary Care Physician (PCP):

Marital Status: __________________________ Spouse's Name (if any):________________________

Parent's Name (if patient is a child):____________________________Parent's DOB _____________

PARENTS OF CHILDREN UNDER AGE 18: **Please sign if you authorize the doctors to treat your child in your absence. (Parent's Signature): ____**

Although we have scanned your card you must fill in the policy information below.

INSURANCE INFORMATION (PLEASE PRESENT YOUR CARDS)

PRIMARY INSURANCE PLAN NAME: ____

Policyholder's Name:____________________________Policyholder's Date of Birth:____________________

SECONDARY INSURANCE PLAN NAME: _____________________________________

Policyholder's Name: ____________________________Policyholder's Date of Birth: ___________________

Name: DOB:

Pharmacy Name: ____________________Address: __________________________

CURRENT MEDICATIONS AND DOSAGE

(PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING)

If you have a medication list please give it to the nurse.

____

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____

____

LIST ANY **MEDICATION AND NON-MEDICATION ALLERGIES**
(FOR EXAMPLE: PENICILLIN, LATEX, PEANUTS)
IF YOU HAVE NO KNOWN ALLERGIES, WRITE "NONE"

____

____

____

FAMILY HISTORY **(please circle all family member(s) with the following medical conditions)**

Melanoma Father Mother Brother Sister Son Daughter

Other skin cancer Father Mother Brother Sister Son Daughter

Psoriasis Father Mother Brother Sister Son Daughter

Eczema Father Mother Brother Sister Son Daughter

Have you had the pneumonia vaccine in the last 5 years? NO YES

Have you have the Flu vaccine? NO YES When? __________

Have you had the Covid vaccine? NO YES When? __________

NAME: DOB:

MEDICAL HISTORY QUESTIONNAIRE

Local Anesthesia		
Problems with local anesthetics (novacaine, lidocaine, etc.)	No	Yes
Problems with adrenaline (epinephrine) when injected	No	Yes
Heart History		
Pacemaker	No	Yes
Defibrillator	No	Yes
Heart Valve Replacement (Specify):	No	Yes
Elevated Blood Pressure	No	Yes
Heart Attack	No	Yes
Bypass Surgery	No	Yes
Other Heart Disease (Specify):	No	Yes
GI Illnesses		
Ulcerative Colitis	No	Yes
Crohn's Disease	No	Yes
Peptic Ulcer	No	Yes
Other GI Disease (Specify):	No	Yes
Kidney		
Kidney Disease	No	Yes
Dialysis	No	Yes
Other Kidney Disease	No	Yes
Arthritis		
Joint Replacement (Specify):	No	Yes
Rheumatoid Arthritis	No	Yes
Lupus	No	Yes
Other Related Disease:		

Organ Transplant (Specify):	No	Yes
Blood Disorders		
Blood/Lymph Disorder (Specify):	No	Yes
Infections		
Hepatitis C	No	Yes
Tuberculosis	No	Yes
Other Infections (Specify):		
Eye Disease		
Glaucoma	No	Yes
Other Eye Disease (Specify):		
Cancer History		
Breast Cancer Right or left	No	Yes
Other Malignancy	No	Yes
Type of Cancer:		
Undergoing treatment	No	Yes
Endocrine		
Diabetes	No	Yes
Type I or Type II		
Thyroid Disease	No	Yes
PCOS	No	Yes
Other Endocrine (Specify):		
Lung Disease		
Asthma	No	Yes
Other (Specify):		
Other Disease Not Mentioned Above:		
Specify:		

Pregnancy: Please inform us if you are pregnant or breast feeding or planning on becoming pregnant during the treatment period	No	Yes

NATOW, ROSENBERG & PION, M.D.s, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, ___________________________________

Have been informed that Allen Natow M.D., Irene Rosenberg M.D. & Ira Pion M.D., P.C. each has a formal written policy regarding privacy practices in accordance with federal law. I further acknowledge that I may be provided with a printed copy of that full policy at any time of my choosing.

Except for those individuals and parties specifically designated by me below, and except for communication with my other health care providers, no information regarding my medical care will be disclosed to any outside individual or party until Allen Natow M.D., Irene Rosenberg M.D. & Ira Pion M.D., P.C. receives written consent from me.

However, I grant Natow Rosenberg & Pion, M.D.s, P.C. to leave telephone messages on the phone number that I have provided as my preferred phone contact number.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The following individual(s) are authorized by me to receive any protected health information about me [e.g. spouse, parent, child]:

Name: ______________________________ Contact #: ________________________________

Name: ______________________________ Contact #: ________________________________

This authorization will expire on: (no date is required):_________________________________

___________________________________ ________________

Signature of Patient Date

PATIENT AUTHORIZATION FOR Allen Natow M.D., Irene Rosenberg M.D. & Ira Pion M.D., P.C. TO OBTAIN MEDICATION HISTORY AS PROVIDED BY SURESCRIPTS

I hereby authorize Allen Natow M.D., Irene Rosenberg M.D. & Ira Pion M.D., P.C. to query Surescripts (http://surescripts.com) and obtain medication history from time to time as needed to update my medical record and perform e-prescribing functions on my behalf.

_______________________________ ________________

Signature of Patient Date