

Niagara Primary Care Registration Form

Dr. Miss Mr. Mrs. Ms. Sir I'm a Jr. I'm a Sr.
Patient's Name: (Last) _____ (First) _____ (MI) _____
Mailing Address _____ City, State, ZIP _____
Home Phone _____ Cell Phone _____ Work Phone _____
*Date of Birth (MM/DD/YYYY) _____ Sex: Male Female Other _____
Social Security Number _____ Primary Care Provider (PCP) _____
Marital Status: Married Single Divorced Widowed Legally Separated Partner
E-mail Address _____ I **want** to have access to the **patient portal**
Language _____ Race _____ Ethnicity _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ Phone Number _____
Emergency Contact Relationship to Patient _____ Guardian
Address _____ City; State; Zip: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: Self Another Patient Guarantor Check here if information is same as patient
Responsible Party Name: (Last) _____ (First) _____ (MI) _____
Date of Birth (MM/DD/YYYY) _____ Male Female Phone # _____
Mailing Address _____ City, State, ZIP _____
Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Their Phone # _____
Name of Insured _____ Patient Relationship to Insured _____
Subscriber ID (Policy Number) _____ Person Code _____ Group ID _____
Insured Date of Birth _____ Insured's Social Security Number _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Their Phone # _____
Name of Insured _____ Patient Relationship to Insured _____
Subscriber ID (Policy Number) _____ Person Code _____ Group ID _____
Insured Date of Birth _____ Insured's Social Security Number _____

PHARMACY INFORMATION

Pharmacy Name _____ Their Phone # _____
Address _____ City; State; Zip _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____

Name: _____

Height: _____ ft _____ in

Weight: _____ lbs

List the name, dosage, and frequency of the medications you are currently taking:

I don't take any medications

Current Medications	Dosage	Frequency

Please provide your PAST MEDICAL HISTORY:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> MI (heart attack) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> GERD (reflux) | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> COPD (emphysema) | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> CAD (heart disease) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Renal disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> BPH (enlarged prostate) | <input type="checkbox"/> Diabetes, type _____ | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> AIDS/HIV |

Other past medical history: _____

Do you have any allergies? If so, list below: No Known Drug Allergies

Allergy	Reaction or Side Effect

Please tell us about any SURGERIES you have had, and indicate the DATE/YEAR if known: None (never had any surgeries)

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Colectomy (colon removed) | <input type="checkbox"/> Pacemaker | Gender Specific Female: | |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Small bowel resection | <input type="checkbox"/> Thyroidectomy | | <input type="checkbox"/> Breast augmentation |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Gastric bypass | <input type="checkbox"/> Tonsillectomy | | <input type="checkbox"/> Bilateral tubal ligation |
| <input type="checkbox"/> Arthroscopy knee | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Tympanoplasty | | <input type="checkbox"/> Breast biopsy |
| <input type="checkbox"/> Back surgery | <input type="checkbox"/> Hip replacement | | | <input type="checkbox"/> Cesarean section |
| <input type="checkbox"/> CABG (open heart surgery) | <input type="checkbox"/> Knee replacement | | <input type="checkbox"/> D & C | |
| <input type="checkbox"/> Carpal tunnel release | <input type="checkbox"/> LASIK | Gender Specific Male: | <input type="checkbox"/> Hysterectomy | |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Liver biopsy | <input type="checkbox"/> Prostatectomy | <input type="checkbox"/> Mastectomy | |
| <input type="checkbox"/> Cholecystectomy (gallbladder) | <input type="checkbox"/> Mastoidectomy | <input type="checkbox"/> TURP | <input type="checkbox"/> Breast reduction | |
| <input type="checkbox"/> Eartube/BMT | | <input type="checkbox"/> Vasectomy | | |

Other past surgical history: _____

Past Hospitalizations unrelated to surgery: _____

Please provide your FAMILY HISTORY: (circle your answer)

Father: Alive Deceased Unknown
Mother: Alive Deceased Unknown
Paternal Grand Father: Alive Deceased Unknown
Paternal Grand Mother: Alive Deceased Unknown
Maternal Grand Father: Alive Deceased Unknown
Maternal Grand Mother: Alive Deceased Unknown

Medical History: _____
Medical History: _____
Medical History: _____
Medical History: _____
Medical History: _____

Do you have any siblings? _____ brother(s) _____ sister(s)
Do you have any children? _____ son(s) _____ daughter(s)

Please provide your SOCIAL HISTORY:

Smoking status: current cigarette smoker If you're a current smoker, when did you start ____/____/____
How many cigarettes a day do you smoke? _____
Are you interested in quitting? Yes Maybe No
 former cigarette smoker If you're a former smoker, when did you start? ____/____/____
And when did you stop smoking?.....____/____/____
 never smoked cigarettes

Do you drink alcohol?

No
 Socially
 Daily

Who do you live with?

Alone Family
 Spouse Friends
 Significant Other Other

Occupation?

Work full-time Retired
 Work part-time Unemployed
 Self-employed Other

Do you have any pets?

cats/kittens dogs/puppies birds reptiles
 fish rabbits guinea pigs other _____

******IMPORTANT******

Have you had any recent labs/blood work, imaging, primary care doctors visits, specialist doctors visits, etc?

List which facility/doctor you went to for each AND what you had done: _____

REVIEW OF SYMPTOMS: Are you currently experiencing any of the following?

Constitutional

Fatigue
 Fever
 Night Sweats
 Weight loss

Cardiovascular

Chest pain
 Irregular heartbeat
 Shortness of breath
 Swollen ankles

Ears/Nose/Throat

Dizziness
 Hearing loss
 Ringing in ears
 Change in vision

Musculoskeletal

Back pain
 Joint pain
 Muscle aches
 Stiffness

Respiratory

Cough
 Trouble breathing
 Wheezing
 Sleep apnea

Neurologic

Balance problems
 Headaches
 Numbness
 Seizures

Skin & Breast

Hair loss
 Rash
 Skin lesions
 Pain in breast(s)

Genitourinary

Genital discharge
 Frequent urination
 Excessive hunger
 Painful urination

Psychiatric

Anxiety
 Depression
 Irritability
 Insomnia

Hem/Lymph

Anemia
 Bruising easily

Authorization to Treat and Acknowledgement of Financial Responsibility

I understand that this authorization includes my consent for medical tests, procedures, drugs and other services and supplies as considered advisable. This treatment may include, but is not necessarily limited to, anesthesia, pathology, radiology and other imaging and diagnostic services, and other special tests and services including tests for communicable diseases and toxins, as ordered by the physician responsible for my care during my visit. I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of my examination, care, or treatment. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information, and that failure to do so can adversely impact my care.

I request that payment authorized by my insurance company, the Center for Medicare and Medicaid Services, or its carriers, be made on my behalf for services provided. I certify that any information I provide related to my eligibility for coverage or payment is accurate and complete. I understand that it is my responsibility to notify the practice of any changes in my coverage. I understand that I am financially responsible for payment of services provided during this visit if I do not have insurance coverage or if I have coverage and timely payment is not made. I also understand that if I have a co-payment for this service, co-insurance, high deductible, or any appointment fee, it is payable on the date of service. I may be charged an additional fee to cover the cost of billing the co-payment, if not paid today. I understand that I am responsible for paying the amount of any discount imposed by my insurance provider or third party payer imposed discounts.

Some insurance companies require pre-authorization services. If I am required to obtain an authorization for today's visit and have not done so, I agree to assume all financial responsibility. If I receive any additional services from specialists, hospitals, or other healthcare providers in connection with, or as a result of this visit, those charges may also be my responsibility, unless pre authorized as required by my insurance company.

I authorize the release of medical or other information to my insurance company, the Center for Medicare and Medicaid Services, or its carriers as necessary to determine payment for these or related services.

Certain lab tests may be sent to an independent lab for processing. I understand that I may receive a separate bill for these services.

In the event that collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to: court costs, expenses, and attorney fees, to the extent permitted by law. I understand that the foregoing provision applies equally to myself or any individual for whom I am authorizing treatment.

Notice of Privacy Practices Acknowledgement

In general, the HIPAA Privacy Rule (Health Insurance Portability and Accountability Act of 1996 – Federal Law) gives individuals the right to request a restriction of uses and disclosures of their Protected Health Information (PHI). It also provides the right to request confidential communications between an individual and his/her physician's office.

To protect your privacy and in keeping with the Federal Privacy Law, all of your medical information, PHI, is kept strictly confidential. We will use this PHI for treatment, payment, and operations (TPO) of our medical practice. We will be required to get an authorization in writing from you if we intend to use your PHI for any other purpose.

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By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** of our facility, give **Authorization to Treat**, and acknowledge your **Financial Responsibility**. Our notice of Privacy Practices is subject to change.

Printed Name: _____ Today's Date: ____/____/____

Signature: _____ (Patient / Parent / Legal Guardian)

“No Show’ and “Cancellation” Policy & Procedure

Our goal is to provide quality care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients. The following policy is with regard to patients who fail to keep their scheduled appointment.

Please be courteous and call our clinic promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of an appointment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to medical care.

- Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a “No Show/Cancellation” fee of \$30.00.

If cancelled by the physician as a medical necessity, then the patient is not subject to this charge.

- This fee is not covered by insurance and is therefore the sole responsibility of the patient.

How to Cancel Your Appointment:

To cancel or reschedule appointments, call our clinic at 716-297-2052.

If you have any problems getting through, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

Patient Signature

_____/_____/_____
Date

Patient Printed Name

_____/_____/_____
Date

Electronic Communication Consent Form

I consent that Som Medical Practice PLLC can provide their services and communicate with me via mobile phone, messages, e-mail and any kind of online communications, provided that these communications comply with privacy regulations.

Appointment Reminders, Reschedules and Cancellations

I understand that Som Medical Practice PLLC can reach me at any time to remind me of my appointments or let me know in case of any change about my appointments. And I also understand that Som Medical Practice PLLC can employ and use a third-party automated system to reach out to me for the purpose of "confirm", "reschedule" or "cancel".

Telemedicine Appointments

For telemedicine, I understand the appointments will be held via electronic environments.

Contact Information Change

I accept that I am responsible for notifying Som Medical Practice PLLC when my contact information changes.

Consent Cancellations

I know that I can revoke this consent at any time by contacting Som Medical Practice PLLC.

I consent to the use of mobile phone communications.

Yes No

I consent to the use of texting (messages) communications.

Yes No

I consent to receive electronic notifications for confirming, rescheduling or cancelling my appointments.

Yes No

Patient Signature

Patient Printed Name

_____/_____/_____
Date

We have exciting news regarding your health care!

As we continue in our efforts to provide you, our patients, with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of but also involved in the maintenance and improvement of your health.

To that end, we are proud to announce that our practice now offers you the opportunity to use the power of the web to track all aspects of your health care through our office. The Patient Portal enables our patients to communicate with our practice easily, safely, and securely over the Internet.

The Portal is a secure and convenient place to manage your health records and those of your family members as well.

Here are just some of the many features that think you will find useful.

Medical History

View your medical history (and that of family members). Medical History includes your Problem List, Allergies, Immunization Record, Lab/imaging/procedure results, and Medication List.



Appointments

Schedule, reschedule, or cancel appointments online. Receive appointment confirmation/reminder notifications.



Request Refills from your doctor

Request refills of authorized medications before you run out. Improved compliance means improved health outcomes.



Lab Reports

View the results of labs, imaging studies, and procedures once your healthcare provider has reviewed them.



Begin today to take an active role in managing your health care! **Print your Email Address below** to be added to the patient portal. You will receive a welcome email and instructions on how to access the portal.

Email Address: _____

NEW YORK HEALTH CARE PROXY AND LIVING WILL – PAGE 1 OF 3

Part I.

I, _____,
(name)

hereby appoint: _____ as my health care agent.

(name, home address and telephone number of agent)

In the event that the person I name above is unable, unwilling, or reasonably unavailable to act as my agent, I

hereby appoint: _____ as my health care agent.

(name, home address and telephone number of agent)

This health care proxy shall take effect in the event I become unable to make my own health care decisions. My agent has the authority to make any and all health care decisions for me, except to the extent that I state otherwise here:

Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

When making health-care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

My agent should also consider the following instructions when making health care decisions for me:

Part II.

This Living Will has been prepared to conform to the law in the State of New York, and is intended to be “clear and convincing” evidence of my wishes regarding the health care decisions I have indicated below.

I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to regarding health care under the circumstances indicated below:

LIFE-SUSTAINING TREATMENTS

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Choice 1 OR Choice 2)

Choice 1. The Choice **NOT** To Prolong Life

I do not want my life to be prolonged if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes. While I understand that I am not legally required to be specific about future treatments if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:

- I do not want cardiac resuscitation.
- I do not want mechanical respiration.
- I do not want artificial nutrition and hydration.
- I do not want antibiotics.

OR

Choice 2. The Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN:

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

OTHER WISHES:

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

NEW YORK HEALTH CARE PROXY AND LIVING WILL – PAGE 3 OF 3

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind. My agent, if I have appointed one in Part I or elsewhere, has full authority to resolve any question regarding my health care decisions, as recorded in this document or otherwise, and what my choices may be.

OPTIONAL ORGAN DONATION:

Upon my death: (choose only one applicable box)

Option 1. I **do not** give any of my organs, tissues, or parts and do not want my agent, guardian, or family to make a donation on my behalf;

Option 2. I give **any needed** organs, tissues, or parts;

OR

Option 3. I give **the following** organs, tissues, or parts only: _____

My gift, if I have made one, is for the following purposes (strike out any of the following you **do not** want):

- 1. Transplant
- 2. Therapy
- 3. Research
- 4. Education

Part III.

Signed _____ Date _____

Print Name _____

Address _____

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Signed _____ Date _____

Print Name _____

Address _____

Witness 2

Signed _____ Date _____

Print Name _____

Address _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date _____ Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all
Somewhat difficult
Very Difficult
Extremely Difficult

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all
Somewhat difficult
Very Difficult
Extremely Difficult

