Laura Martin, DO

1304 Buckley Road – Suite 302
Syracuse, NY 13212
(315) 671-5790

Patient Registration Form

Please Print

Date_____

Name:_____ Sex ___F ___M SS#_____
Address:_____City_____Zip_____
Mailing Address (if different than above)_____
Phone_____ Cell Phone_____ Age_____ DOB _____
Marital Status: Single_____ Married____ Divorced/Separated_____ Widow/Widower_____
Patients Employer_____ Occupation_____
Employers Address_____ Work Phone_____
Emergency Contact_____ Phone _____
Spouse/Significant Others Name_____ Mother's Maiden Name_____
Spouse/Significant Others DOB:_____ SS#_____
Spouse's/Significant Others Employer _____ Occupation_____
Employers Address _____Work Phone_____
Pharmacy Name & Address_____ Pharmacy Phone #_____
Language Preference_____ Race_____ Email _____
Ethnicity Non-Hispanic/Spanish Origin ____ Spanish/Hispanic Origin_____ Patient Declined/Unknown_____

INSURANCE INFORMATION

Primary Insurance Company:_____Subscriber Name:_____
ID#:_____ SS#:_____DOB:_____
Secondary Insurance Company.:_____ Subscriber Name:_____
ID#:_____

HIPAA DOCUMENTATION

(Please answer all questions below and then sign and date)

1 **I acknowledge that I have been given the opportunity to read and/or receive a copy of Family Care Medical Group's Privacy Notice. YES NO**

2.

Leave appointment message on:	YES	NO
Home Phone (including autocall)?		
Mobile Phone (including autocall)?		
Mobile Text (including autocall)?		
Work Phone?		
With another person? List name(s) below		
Send via Mail?		
Send via Email?		

Leave Medical Information on:	YES	NO
Home Phone (including autocall)?		
Mobile Phone (including autocall)?		
Mobile Text (including autocall)?		
Work Phone?		
With another person? List name(s) below		
Send via Mail?		
Send via Email?		

3. Person(s) authorized to discuss the above information & relationship

_____ _____

_____ _____

Signature_____ Date_____

*** I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Signature_____ Date_____

*** I authorize the payment of medical benefits to above stated physician or supplier for services rendered.

Signature_____ Date_____

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Date of last mammogram _____

Are you pregnant? _____

Number of children _____

Number of pregnancies ____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

_____

Pharmacy Name _____ Phone _____

Last Tetanus _____

Last flu shot _____

Last Pneumovax _____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer /Type	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Sunscreen Y/N Seatbelt Y/N

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Alcohol	

Exercise: _____

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____
Reviewed By — Date

My Care Family Practice
Laura Martin, DO
Vince Gemelli, PA

1304 Buckley Road – Suite 302
Syracuse, NY 13212
315.671.5790

No Show Fee & Cancellation Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences.

Due to high patient demand and limited availability of appointments, we have instituted a fee of $25.00 for a no show, $25.00 for a late cancellation, and $50.00 for a physical exam no show.

You must provide 24 hour advance notice to cancel or reschedule an appointment.

By signing below, I acknowledge that I have read and understand this policy.

_____	_____
Patient Signature	Date
_____	_____
Patient Name (printed)	Acct #
_____	_____
Witness Signature	Date

NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute

HIV-Specific Model Consent Form

My health care provider has answered any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling my sex or needle-sharing partners of possible exposure.

I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

Patient Name: _____ Date: _____

Signature: _____
Patient or person authorized to consent

Medical Record #: _____

Laura Martin, DO
My Care
Controlled Substance Agreement

The health care providers at My Care are committed to giving you, the patient, excellence in health care. This includes their approach to pain management and other conditions that may require the use of controlled substances. The following agreement is a tool to protect both you and the health care providers by establishing guidelines for proper controlled substance use. This agreement also gives guidelines for your expected responsibilities and behavior.

1) I acknowledge that the decision to initially prescribe or continue to prescribe any controlled medication is entirely at the discretion of the health care provider. I also acknowledge that the providers at My Care do not specialize in managing pain and at any time may make the decision to refer their patients to a pain management specialist.

2) I will not attempt to get controlled substances from other offices or providers without first discussing it with my primary care provider at My Care. If I am seen in an Urgent Care or Emergency Room facility and am given a controlled substance, I will notify my health care provider of what I received and the amount received within 72 hours.

3) I will follow the prescription exactly as written.

4) I am aware that refills will be made at the discretion of the health care provider. They will only be done during regular office hours. Refills will not be done during evenings, weekends or holidays. Refills must be picked up at the My Care office, or can be mailed to the pharmacy. I understand that it is my responsibility to keep my medications safe and to use them appropriately. Refills will not be given early under <u>any</u> circumstances, including but not limited to running out early, loss or theft of a prescription, or any sort of damage to medication. I will give this office at least 48 hours notice before needing a refill. Prescriptions will not be post-dated.

5) I will schedule follow-up appointments with my health care provider every 3 months. I understand that this does not mean that I will receive a 3 month supply of any prescriptions. Controlled substances will be prescribed only one month at a time.

6) <u>I agree to comply with random (unannounced) drug testing. I will also bring my prescription bottles of all controlled substances with me to my appointments to document proper use of medicines.</u>

7) I will not share, sell or permit others, including spouse and family members, to have access to my controlled substances.

8) I will obtain all medications at the same pharmacy and will inform this office should I need to change pharmacies for any reason. The name of the pharmacy I have selected is: _____.

9) I understand that failure to abide by this agreement may result in dismissal from My Care.

_____ _____
Patient name date of birth

_____ _____
Patient signature Date

(Form revised August, 2012)

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Here at My Care Family Practice, we try our very best to provide each patient with the quality of care you deserve. Please understand that certain services take more time and attention to complete.

Please be aware that there is a 24-48 hour waiting period on all medication refills, and any controlled substances prescriptions must be picked up by the patient at our office. We cannot mail them to the patient or the pharmacy. It is best to notify your nurse at your appointment if you need any upcoming refills.

The doctor requires a minimum of 10 busienss days to complete any paperwork. Physical, school and work forms may require an office visit to be completed. If you are unsure if a visit is needed to complete the form, please check with the receptionist.

We value your time and we try to allow for plenty of time with each patient. For that reason, if you are going to be 15 minutes late or longer for a scheduled appointment, we ask that you reschedule. If you do not notify the office 24 hours in advance, your account will be billed a $25.00 no show fee. In the event of an emergency, your account will not be charged.

MyCare accepts a large number of different insurances. Please be aware that your physical may not be covered under your insurance, and you will be responsible for any uncovered charges. If you are unsure if your physical will be covered, please contact your insurance carrier prior to your appointment.

Please sign and date below to acknowledge that you have read and agree to these policies.

Signature:_____ Date:_____