New Patient Interview for Endocrinology

Name: _____ DOB: _____

Phone Number: _____ Mobile Carrier: _____

Address: _____

Insurance: _____

Medicare #: _____ Medicaid#: _____

1. Do you have any chronic medical conditions?

2. Are you currently taking any medications? If so, what are they?

3. Why were you referred to an Endocrinologist & who referred you? **Referral must be on file prior to scheduling.**

4. Who is your PCP? When were you last seen?

5. Are you covid vaccinated?

6. Have you seen an Endocrinologist before? If so, who? When were you last seen?

7. Have you had radiology testing w/in the last year? If so, when & where?

8. Have you had labs done w/in the last year? If so, when & where?

Non-Disclosure Policy

Primary Care, Rheumatology, Sleep, Physiatry, Endocrinology & Psychiatry require a new patient interview prior to being scheduled. If at the time of the patient's appointment it is determined false information and/or not all requested information was given by the patient during the new patient interview the provider can refuse to see the patient. The patient will then be released from the practice.

Please initial _____ Date _____

Medical Associates of the Hudson Valley, P.C.

Personal and Family Health History Questionnaire Form

Please complete both pages of this medical history form and send back to the office. Thank you.

Main address: 360 Washington Ave. Kingston, N.Y. 12401 (3rd floor)

Phone #: 845-338-7140 **Fax #:** 845-338-7141

Date: _____ Name:_____ Date of birth: _____

Please list all dates, name of doctors and/or facilities for all procedures performed or N/A if non-applicable.

Procedure:	Date last Performed:	Location:	Doctors Name:
Physical			
PAP			
Mammography			
Colonoscopy			
Blood Work/Lyme Testing			
Bone Density			
Covid Vaccine Dates	**Moderna_☐_** **Pfizer_☐_** **J & J__☐__**	**1st dose _____**	**2nd dose _____**
Consent for Vaccine download from NYSIIS	**Yes___☐___** **No___☐___**		
List any radiology or imaging (MRI, CT, X-Ray)			

Allergies **(List all)** _____
(Allergy Consults) Pets & Flooring Materials_____

Medical Problems **(List all)** _____
_____

Foot Exam and Doctor **(If Diabetic)** _____
Eye Exam and Doctor **(If Diabetic)** _____

Surgeries **(List all with dates & locations preformed)** _____
_____

Medical Associates of the Hudson Valley, P.C.

Hospitalizations **(List all with dates and hospital names, EXCLUDING SURGERIES)** _____

_____

Medications **(List all meds with name and dosage, including daily over the counter meds and supplements)**

_____

_____

_____

Family Medical History: (Please list any known illnesses, cancers, or medical conditions, <u>if relative is living or deceased [if so, cause of death])</u>

Father _____

Mother _____

<u>Social History</u>

Marital Status _____

Miscarriage or Abortions _____

Occupation/Retired From_____

Have you ever been a smoker?

Never ☐ Former ☐ Current ☐ # of packs per day _____

Cigarettes ☐ Cigars ☐ Vape ☐ Other _____

Start date: _____ End date: _____

Alcohol consumption: Wine ☐ Beer ☐ Liquor ☐

Quantity: Daily _____ Weekly _____ Occasional _____ None _____

Sleep Habits: Good ☐ Fair ☐ Poor ☐ Trouble falling asleep ☐ Trouble staying asleep ☐

CPAP/BiPAP ☐ Sleep Study (Date/Facility Performed at) _____

Hand Dominance: Right ☐ Left ☐ Ambidextrous ☐

Please list any other providers on your care team that we would be able to obtain records from.

_____

_____

_____

_____

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed: Medical Associates of the Hudson Valley
Phone (845) 338 7140 Fax (845) 338 7141 360 Washington Ave., Kingston, NY 12401

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until revoked (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs	Initial assessment and last two visits	
☐ Clinical records from mental health programs*	Initial assessment and last two visits	
☐ HIV/AIDS-related Information	All	

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW _____ DATE _____

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

STAFF PERSON'S NAME AND TITLE _____ SIGNATURE _____ DATE _____

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.