Neil Tanna, MD, FACS
T: 516-321-8900 Fax: 516-224-2390
Email: TeamTanna@Northwell.edu
600 Northern Boulevard, Suite 310, Great Neck, NY 11021

REGISTRATION FORM

PATIENT INFORMATION

Patient Name:	Sex:	DOB:	Marital Status:
Home Address:	City:	State:	Zip:
Home Phone: / Cell Phone:	Email Address:		
Preferred Language:	Race / Ethnicity:		
Employer Name:	Work Phone:		
Employer Address:	City:	State:	Zip:

EMERGENCY CONTACT

Contact Name:	Relationship:	Phone:
Guarantor Name : (If patient under 18 or disabled)	Relationship:	Phone:

PHYSICIAN INFORMATION

Primary Care Physician:	Address:	City:	Phone:
Referring Physician:	Address:	City:	Phone:

INSURANCE INFORMATION

Primary Insurance Name:	Policy #:		Group #:	
Address	City:	State:	Zip:	Phone:
Insured's Name: / Relation to Insured:	Insured's DOB:		Effective Date:	
Secondary Insurance Name:	Policy #:		Group #:	
Address:	City:	State:	Zip:	Phone:
Insured's Name: / Relation to Insured:	Insured's DOB:		Effective Date:	

PHARMACY INFORMATION

Pharmacy Name:			
Pharmacy Address:	City:	State:	Zip:
Pharmacy Telephone Number:			

AUTHORIZATION TO RELEASE INFORMATION VIA E-MAIL

By providing your e-mail address you agree to receive by e-mail address information about your healthcare, including protected health information.

SIGNATURE OF PATIENT OR AUTHORIZED GUARDIAN _____ *Date:* _____

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PATIENT MEDICAL HISTORY

Patient Name:	DOB:

Reason for Visit

Chief Complaint:

How long have you had this problem:	Is there pain involved? ❑ Yes ❑ No

Medications / Medication Allergies

Please list current medications:

Medication allergies (list drugs and reaction to them):

Please list current vitamins and supplements you are taking:

Pacemaker

Do you have a pacemaker: ❑ Yes ❑ No	If yes, please provide the MAKE and MODEL #:

Hospitalizations

Please list all admissions to the hospital and the reason for admission:

Social History

Do you currently use Tobacco: ❑ Yes ❑ No		If yes, # cigarettes / day:	How many years smoking?	
If no, have you ever used Tobacco? ❑ Yes ❑ No		If yes, when did you quit?	If yes, # cigarettes / day:	
Do you consume Alcohol? ❑ Yes ❑ No		If yes, please specify how often:		
Have you taken any steroids or prednisone in the last 6 months?	❑ Yes ❑ No	If yes, what did you take?	When?	Frequency / Dosage:

Family History

Please list all illnesses that run in your family:

Healthcare Proxy

Do you have a living will/health care proxy? ❑ Yes ❑ No	If no, would you be interested in receiving information on it? ❑ Yes ❑ No

FOR WOMEN ONLY:

Age at first menstrual period:	Date of last menstrual period:	How many times have you been pregnant?	Age at first pregnancy:

# Miscarriages:	# Terminations:	How many children do you have:	Did you breast feed? ❑ Yes ❑ No	If so, how long?

Have you ever taken birth control pills? ❑ Yes ❑ No	If yes, for how long and when?	Family history of breast cancer? ❑ Yes ❑ No	If yes, relationship to you:
Past history of breast disease? ❑ Yes ❑ No	If yes, for how long and when?	Any nipple discharge? ❑ Yes ❑ No	If yes, for how long and when?

Signature of Patient or Authorized Guardian _____ *Date:* _____

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Patient Name:	DOB:

HAVE YOU HAD A HISTORY OF, OR ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? PLEASE INDICATE YES OR NO:

Condition	Response		If Yes, Please Explain
1. Recent fevers, weight loss	❑ Yes	❑ No	
2. Eye problems	❑ Yes	❑ No	
3. Heart or vascular problems:	❑ Yes	❑ No	
a. Heart attack	❑ Yes	❑ No	
b. Congestive heart failure	❑ Yes	❑ No	
c. Chest pain	❑ Yes	❑ No	
d. Heart murmur	❑ Yes	❑ No	
e. Mitral valve prolapse	❑ Yes	❑ No	
f. Phlebitis	❑ Yes	❑ No	
g. Problems with circulation	❑ Yes	❑ No	
h. Problems with heart rhythm	❑ Yes	❑ No	
i. Vascular disease	❑ Yes	❑ No	
j. High blood pressure	❑ Yes	❑ No	
5. Breathing problems:	❑ Yes	❑ No	
a. Asthma	❑ Yes	❑ No	
b. Pneumonia	❑ Yes	❑ No	
c. Tuberculosis	❑ Yes	❑ No	
d. Emphysema or chronic bronchitis	❑ Yes	❑ No	
6. Stomach or Intestinal problems:	❑ Yes	❑ No	
a. Liver disease	❑ Yes	❑ No	
b. Jaundice	❑ Yes	❑ No	
c. Hepatitis	❑ Yes	❑ No	
d. Stomach problems	❑ Yes	❑ No	
e. Ulcers	❑ Yes	❑ No	
f. Hiatal hernia	❑ Yes	❑ No	
g. Bowel Disease	❑ Yes	❑ No	
h. Colitis	❑ Yes	❑ No	
i. Diverticulosis	❑ Yes	❑ No	
7. Kidney, bladder or genital problems:	❑ Yes	❑ No	
a. Prostate disease	❑ Yes	❑ No	
b. Enlarged prostate	❑ Yes	❑ No	
c. Kidney or bladder disease	❑ Yes	❑ No	
8. Problems with muscles or joints	❑ Yes	❑ No	
9. Problems with skin / skin cancer	❑ Yes	❑ No	

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Patient Name:	DOB:

Have you had a history of, or are you currently experiencing any of the following? Please indicate yes or no:

Condition	Response		If Yes, Please Explain
10. Thyroid problems	❑ Yes	❑ No	
11. Diabetes	❑ Yes	❑ No	
12. Problems with brain or spinal cord:	❑ Yes	❑ No	
a. Stroke	❑ Yes	❑ No	
b. Seizures	❑ Yes	❑ No	
c. Fainting	❑ Yes	❑ No	
d. Migraines	❑ Yes	❑ No	
13. Psychiatric problems:	❑ Yes	❑ No	
a. Depression	❑ Yes	❑ No	
b. Suicide attempt	❑ Yes	❑ No	
14. Bleeding disorders:	❑ Yes	❑ No	
a. Bleeding tendencies	❑ Yes	❑ No	
b. Transfusion reactions	❑ Yes	❑ No	
15. History of any cancer	❑ Yes	❑ No	
15. HIV	❑ Yes	❑ No	

Pain Assessment: On a scale of 0 10, please circle the amount of pain you experience:

0 None	1	2	3	4	5 Moderate	6	7	8	9	10 Severe
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Describe the pain (sharp, aching, dull, throbbing, etc.)	
Where on your body is the pain:	When did the pain start:
Is the pain always there or does it come and go:	What makes the pain worse:

Signature of Patient or Authorized Guardian

Date:

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Today's Date: _____
Name: _____ Date of birth: _____
Provider Seen Today:_____

Please answer the following questions to the best of your ability. Circle YES for any of the cancers in your **family.**

The Following Relatives Should Be Considered:

(1st degree) Mother, Father, Brother, Sister, Children,
(2nd degree) Paternal & Maternal Aunts/Uncles, Half Siblings, Nieces/Nephews, Maternal/Paternal Grandparents, (3rd degree) 1st Cousins, Great Aunts/Uncles, Great Grandparents

Cancer History Description	Yes	No	YOURSELF or Relatives (see list above)	Paternal or Maternal?	Age of diagnosis
Have you ever received hereditary cancer genetic testing?	☐	☐			
Have you been diagnosed with breast cancer at any age?	☐	☐			
Has a relative been diagnosed with Breast Cancer before the age of 50 (1st, 2nd degree)	☐	☐			
Have you or a relative been diagnosed with Ovarian Cancer at ANY AGE (1st, 2nd degree)	☐	☐			
Are you Ashkenazi Jewish and have a diagnosis of breast cancer in you or a relative at ANY AGE (1st, 2nd degree)	☐	☐			
Have you or a relative been diagnosed with metastatic breast or metastatic prostate cancer at ANY AGE (1st, 2nd degree)	☐	☐			
Have you or a relative been diagnosed with Pancreatic Cancer at ANY AGE (1st, 2nd degree)	☐	☐			
Three or more of the following on the same side of the family diagnosed at ANY AGE: prostate or breast (1st, 2nd, 3rd degree)	☐	☐			
Have you or a relative been diagnosed with Male Breast Cancer at ANY AGE (1st, 2nd degree)	☐	☐			
Three or more of the following cancers (circle) on one side of family diagnosed at ANY AGE: colon, endometrial, gastric, ovarian, brain, pancreatic, small bowel, hepatobiliary tract, renal, or sebaceous adenomas (Patient, 1st, 2nd & 3rd degree)	☐	☐			
Have you or a relative been diagnosed with Colon Cancer before the age of 50 (1st, 2nd degree)	☐	☐			
Has a relative been diagnosed with Uterine/Endometrial cancer before the age of 50 (1st, 2nd degree)	☐	☐			
Have you been diagnosed with Endometrial/Uterine cancer at or before the age of 64	☐	☐			

Patient Signature: _____ MD signature: -
_____ Date: ___/___/___
Notes:

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PROBLEM / SUMMARY LIST
DIAGNOSIS / SURGERY
ALLERGIES / MEDICATIONS

PATIENT NAME:

DATE OF BIRTH:

▪PRIMARY CARE PROVIDER____PHONE #____________________

SIGNIFICANT MEDICAL DIAGNOSES / CONDITIONS	DATE

PREVIOUS MAJOR SURGERIES / PROCEDURES / HOSPITALIZATIONS	DATE

ALLERGIES	REACTION

MEDICATION	DOSE	FREQUENCY	DATE	DATE	DATE	DATE	DATE

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PATIENT FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

I understand that **Northwell Health Physicians Partners**, my treating physicians and their respective designees, will use and disclose my health information for all purposes necessary for treatment, payment and heath care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

- **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to Northwell Health. I understand that I am financially responsible for non covered services. I authorize the release of any medical or other information necessary for discharge planning purposes.
- **FINANCIAL LIABILITY:** I have been provided a copy of the Northwell Health Physicians Partners financial policies and agree to the specific terms. I agree to pay all charges (or to become due) to Northwell Health Physicians Partners for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party will be credited on account. I understand that I will be responsible for any charges if any of the following apply:
    - My plan requires prior referral by a Primary Care Physician (PCP) before receiving services at Northwell Health and I have obtained such referral or I receive services in excess of the referral, and/or
    - My health plan determines that the services I receive at Northwell Health are not medically necessary and/or not covered by my insurance plan, and/or
    - My health plan coverage has lapsed or expired at the time I receive services at Northwell Health, and/or
    - I have chosen not to use my health plan coverage, and/or
    - The physician I see does not participate with my health care plan.
- **MEDICARE SIGNATURE ON FILE (Medicare patients only):** I request payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patients Medicare Number:_____ Patient Signature: _____

- **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at Northwell Health; such as, anesthesia, interpretation of cardiac tests, imaging services (e.g. X-rays, Ultrasounds, MRI's) and pathology specimen examination. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payer.
- **CANCELLED OR NO SHOW APPOINTMENTS:** I understand that, based on the policy of individual physician offices, I may incur a cancelation fee if I do not provide the required notice of cancelation, or if I do not keep my appointment and have not canceled.

I have read and understand the Northwell Health Physician Partners financial policies above .

_____ _____
Patient Signature **Date**

_____ _____
Guarantor Signature (if patient is under 18) **Date**

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Patient Name:

Date of Birth:

Authorization for Release of Information by Northwell Health

Insurance Companies and Third Party Payer- I hereby authorize and direct Northwell Health, having treated me, to release to governmental agencies, insurance carriers or others who are finically liable for my hospitalization and medical care, all information need to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Discharge Planning Services- In the event that I require post-hospital services upon my discharge from Northwell Health, I hereby authorize Northwell Health to release medical record information, including my (the patients) medical record, portions thereof or information therefrom (as it deems appropriate), to providers of post-hospital care services, including but not limited to residential health care facilities and home care agencies for the purpose of facilitating necessary discharge planning arrangements.

Patient Valuables- It is understood and agreed that the Hospital cannot accept any responsibility for the loss or damage of articles which the patient or legal representative considers valuable. The hospital has no provisions for the safekeeping of money or other valuables and these should either be kept at home or kept in the safekeeping of family or friends.

I release the Hospital from any and all liability for the loss or damage to any "valuables" which I may choose to retain in my assigned room or any storage area therein, despite the warning and advice in this document.

"Valuables": the term includes, but is not limited to, money, credit cards, personal documents, checks, jewelry, clothing, furs, dentures, eyeglasses, hearing aids and personal items to which the patient may attach unusual value.

Financial Agreement- The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services rendered to the patient, he/she herby obligates him/herself to pay the amount of the hospital in accordance with the rates and terms of the hospital. Should the account be referred to any attorney for collection, the undersigned shall pay reasonable attorney fees and all collection expenses.

Assignment of Benefits- I hereby assign, transfer and set over to the above named Hospital sufficient monies and/or benefits to which I may be entitled from the government agencies, insurance carriers or others who are finically liable for my hospital, medical care and treatment to me or my dependent in said hospital.

Assignment of Benefits for Patients Entitled to Medicare Benefits- I certify that the information given to me in applying for payment under the title XVIII of the Social Security Act is correct. I authorize any holder of the medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made on my behalf. I assign the benefits payable for physician series to the physician or organization furnishing the services. In addition I authorize the hospital assignment of my Lifetime Reserve inpatient days should my full Benefit and Co-Insurance inpatient days become exhausted.

The undersigned certifies that he/she has read the forgoing, and is the patient or is duly authorized by the patient as the patient's agent to execute the above and accept its terms.

If the patient is a minor, incompetent or unable to sign:

_____ (Patient Signature)

_____ (Person Responsible Signature)

_____ (Witness Signature)

_____ (Relationship to Patient)

_____ (Date)

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Patient Name:

Date of Birth:

I agree to allow disclosure of my PHI (including date/time of appointments) to:

☐ My spouse_____
(Printed name and phone number)

☐ Member(s) of my family_____
_____
_____
(Printed name and phone number)

☐ Other _____
(Printed name and phone number)

☐ Myself only

I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and reviewed the *Notice of Privacy Practices.*

_____
Print Name of Patient or Legal Representative Date

_____
Signature of Patient or Legal Representative Date

_____
Relationship to patient

Authorization to release information via email

By providing your email address, you agree to receive email information about your healthcare, including protected health information.

_____ _____
Signature Date

This does not serve as an Authorization to Release Medical Records

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other(please specify)

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Acknowledgement of Receipt

I have received a copy of the Provider's Notice of Privacy Practices. (click to download)

Patient/Agent/Relative/Guardian* (Signature) Date / Time Print Name Relationship if other than patient

Telephonic Interpreter's ID # Date / Time

OR

Signature: Interpreter Date / Time Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature) Date / Time Print Witness Name

PROVIDER USE ONLY

_____ Patient or patient representative refused to sign/accept Notice of Privacy Practices

_____ Patient unable to sign

Signature Date / Time

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.