

Neil Baum, M.D.
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PATIENT REGISTRATION FORM

Today's date:		Primary Care Physician:							
PATIENT INFORMATION									
Patient's last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Street address:				City:		State:		ZIP Code:	
Social Security no.:			Home phone no.:			Cell phone no.:			
			()			()			
Birth date:		Age:		Sex:		Pharmacy Name:		Street your pharmacy is on:	
/ /				<input type="checkbox"/> M <input type="checkbox"/> F					
Occupation:			Employer:			Employer phone no.:			
						()			
Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No			Email Address:						
Do you have power of attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, person's name:			Phone Number:			
Referred to Dr. Baum by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Provider		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Website/Internet Search		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other	
Spouse's Name (if applicable):					Spouse's Date of Birth:				

INSURANCE INFORMATION								
(Please give your insurance card to the receptionist.)								
Name of primary insurance:				Group no.:		Policy no.:		
Policy Holder's Name:			Birth date:		Policy Holder's S.S. no.:		Employer:	
			/ /					
Patient's relationship to policy holder:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child		<input type="checkbox"/> Other
Name of secondary insurance (if applicable):				Group no.:		Policy no.:		
Policy Holder's Name:			Birth date:		Policy Holder's S.S. no.:		Employer:	
			/ /					
Patient's relationship to policy holder:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child		<input type="checkbox"/> Other

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:
			()	()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Neil Baum or insurance company to release any information required to process my claims.</p>				
<hr style="width: 100%;"/> <i>Patient/Guardian signature</i>			<hr style="width: 100%;"/> <i>Date</i>	

Patient Information

Patient's last name:	First:	Middle:	Date of Birth:
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Today's Date: ____ / ____ / ____

REASON FOR VISIT TODAY (Please describe your problem/reason for visit in detail):

List Relevant Symptoms:

Are you allergic to any medications? (If so please list)

I have no known drug allergies

Are you on any medications? Please List:

Are you taking any blood thinners? Aspirin Plavix Coumadin (Warfarin)

Do you smoke or use tobacco products?

YES NO If yes, How many packs per day? _____
For how many years? _____

Do you drink alcoholic beverages?

YES NO If yes, How many drinks per day? _____

Do you drink caffeine (soda, coffee, etc)?

YES NO If yes, How many drinks per day? _____

Patient Information

Patient's last name:	First:	Middle:	Date of Birth:
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PATIENT PAST MEDICAL HISTORY: (Please list any medical conditions either current or past)

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes On Insulin? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Cancer (Please specify type)	<input type="checkbox"/> Hypertension (High Blood Pressure)
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Depression
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Dialysis
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Hepatitis A / B / C	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Epilepsy or Seizures
<input type="checkbox"/> Other:		

PATIENT SURGICAL HISTORY: (Please list any surgeries you have had and the year they were performed)

Name of Surgery	Date of Surgery (Year)

FAMILY MEDICAL HISTORY: (Please list any medical conditions in your family and specify which family member)

CONDITION	FAMILY MEMBER (mother, father etc)	CONDITION	FAMILY MEMBER (mother, father etc)
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Prostate Cancer	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Cancer Type-	
<input type="checkbox"/> Stroke		<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Alzheimer's		<input type="checkbox"/> Parkinson's	
<input type="checkbox"/> Heart Attack		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Dementia	
<input type="checkbox"/> Other:			

Patient Information

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FEMALE PREGNANCY HISTORY:

Number of Vaginal Deliveries _____

Number of Caesarians _____

Review of Systems

Have you had any of the following problems recently?

GENERAL:

- | | | |
|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Weight loss or gain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |

EYES:

- | | | |
|--|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Blurry or double vision | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts |
|--|-----------------------------------|------------------------------------|

NEUROLOGICAL:

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Tremors | <input type="checkbox"/> Paralysis/ Weakness |

ENDOCRINE:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Tired/Sluggish | <input type="checkbox"/> Too Hot/Cold |
|---|---|---------------------------------------|

GASTROINTESTINAL:

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Stomach Ulcer |
|---|--|--|

CARDIOVASCULAR:

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Chest pain or discomfort | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Irregular Heart Beat |

SKIN:

- | | | |
|-------------------------------|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Skin Lumps | <input type="checkbox"/> Psoriasis |
|-------------------------------|-------------------------------------|------------------------------------|

MUSCULOSKELETAL:

- | | | |
|---|------------------------------------|------------------------------------|
| <input type="checkbox"/> Muscle or joint pain | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Arthritis |
|---|------------------------------------|------------------------------------|

EAR/NOSE/THROAT/MOUTH:

- | | | |
|---|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Hearing loss |
|---|----------------------------------|---------------------------------------|

RESPIRATORY:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Wheezing |

HEMATOLOGICAL/LYMPHATIC:

- | | | |
|---|--|------------------------------|
| <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Blood Clotting Problems | <input type="checkbox"/> HIV |
|---|--|------------------------------|

PSYCHOLOGIC:

- | | | |
|-------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Suicidal Thoughts |
|-------------------------------------|----------------------------------|--|

Patient Information

Patient's last name:	First:	Middle:	Date of Birth:
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RELEASE OF PERSONAL MEDICAL INFORMATION

I, _____, allow the office of Neil Baum, M.D. to discuss my medical information with the following individuals:

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient

Patient Signature

Date

Expires one year from date signed.

FOR OFFICE USE ONLY

Date:	Initials of Witness:
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Patient Information

Patient's last name:	First:	Middle:	Date of Birth:
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who maybe involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature of Patient or
Legally Responsible Party: _____

Relationship to Patient: _____

Date: _____

Expires one year from date signed

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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