

Appointment w/:	Today's Date:
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Patient Information:

Last Name		First Name		M
Date of Birth	Age	Sex	Marital Status	
Street Address		City/State		Zip Code
Home Phone # ()	Mobile # ()	Work# ()	Email	
Mother's First Name:			Father's First Name:	

This is for medical record purposes only.

Employer Information:

Occupation	Employer's Name/Address
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Emergency Contact Information:

Name	Relationship	Phone # ()
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Referral Source (From whom/how did you hear about this Provider?):

Name/Type: Physician Family or Friend Website/ Search Advertisement Other _____

Primary Care Physician	Address	Phone# ()
Cardiologist	Address	Phone# ()
Physician (Other) _____	Address	Phone # ()

Insurance Information:

Patient Relationship to Guarantor (circle one)	SELF	SPOUSE	DEPENDENT CHILD	STUDENT
Primary Insurance			Policy #	
Guarantor Name			DOB	
Secondary Insurance			Policy #	
Guarantor Name			DOB	

Pharmacy Information:

Circle One:	Retail Pharmacy	Mail-Order Pharmacy	Name
Address			Phone # ()

Authorization for Treatment and Release of Information

I hereby authorize and direct the above named clinical practice having treated me, to release to governmental agencies, insurance carriers, or others financially liable for my medical care, all information needed to substantiate payment for such medical care; and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I furthermore authorize the treating physician/practice to take and use my photos for insurance predetermination and educational purposes.

Financial Responsibility (For Provider Indicated in the "Appointment w/" section of this form)

Medicare Patients: I request that payment of authorized health insurance benefits be made to me or on my behalf to the provider(s) for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.

Commercial/Other Insurance: I hereby authorize direct payment of surgical/medical benefits to my provider, for services rendered by him/her in person or under his/her supervision if I have not paid in advance. I understand that I am financially responsible for all services. Additionally, I understand that all bills are my responsibility if not paid by the carrier.

Out of Network: I understand that the doctor is a **non-participating provider** of my insurance and therefore I will be responsible for any balances on this account.

Self-Pay: I agree to pay at the time the services are rendered.

I verify the accuracy of the above information and authorize treatment and release of information as indicated on this form.	Patient (Guardian) Signature X	Date
I understand and agree to terms of my financial responsibility as indicated on this form.	Patient (Guardian) Signature X	Date



LAST NAME: _____ FIRST NAME: _____ dob: _____

What is the reason for your visit today? _____

Do you have any allergies to medications or other substances? Yes ___ No ___ If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis). _____

_____ Height _____ Weight _____

Please list ALL of your current medications below (use back of page if you need more room)

Medication Name	Dose	When do you take it?	Approximate start date of medication

MEDICAL HISTORY: HAVE YOU EVER HAD (been diagnosed or treated for) ANY OF THE FOLLOWING (if yes, describe):

- Heart Disorder Yes No ___ _____
- Cancer Yes No ___ _____
- Diabetes Yes No ___ _____
- Blood Pressure Disorder Yes No ___ _____
- Thyroid Disorder Yes No ___ _____
- Lung Disorder Yes No ___ _____
- Stomach/Intestinal Disorder Yes No ___ _____
- Skin Disorder Yes No ___ _____

MEDICAL HISTORY Continued:

- Clotting Disorder Yes No ___ _____
- Eye Disorder Yes No ___ _____
- Psychiatric Disorder Yes No ___ _____
- Urinary/Kidney Disorder Yes No ___ _____
- Liver Disorder Yes No ___ _____
- Orthopedic Disorder Yes No ___ _____
- Cholesterol Disorder Yes No ___ _____
- Neurologic Disorder Yes No ___ _____
- Other Yes No ___ _____



LAST NAME: _____ FIRST NAME: _____ dob: _____

FAMILY HISTORY: Please indicate any major conditions/illnesses that your family members have had:

RELATIVE CONDITION & DESCRIPTION LIVING (Y/N) IF DECEASED, AT WHAT AGE?

Mother: _____

Father: _____

Other: _____

SURGICAL HISTORY: List any surgeries you have had and the approximate date:

Have you had a blood transfusion Yes ___ No ___ ? If yes, when? _____

SOCIAL HISTORY:

Occupation: _____ Marital Status: _____ Children? Yes ___ No ___ Their ages? _____

Do you exercise regularly? Yes ___ No ___ Describe your exercise routine: _____

Do you have pets in your home? Yes ___ No ___ Describe: _____ Health Care Proxy _____

Smoking: Currently? Yes ___ No ___ Previously? Yes ___ No ___ Years Smoked _____ Packs per day _____

Other tobacco or substance _____ Date stopped _____

Are/were you exposed to 2nd hand smoke at home or work? Yes ___ No ___ , If "Yes," explain _____

Other substances: Alcohol? Yes ___ No ___ Recreational Drugs? Yes ___ No ___

Describe use _____

Patient Signature _____ Date _____

FOR OFFICE USE ONLY:

CROWN-05-05-09 intake

The following sections were entered into CROWN by (sign initials next to the section(s) you entered):

All _____ Problems _____ Allergies _____ Medical Hx _____
Surgical Hx _____ Family Hx _____ Social History _____

Physician Signature _____ Date _____



**COLUMBIA UNIVERSITY
MEDICAL CENTER**

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA Compliance/Columbia University Medical Center
601 West 168th Street, Apt. #22, 2nd Floor
New York, NY 10032/ T(212) 342-0059 F(212)342-5173
<http://www.cumc.columbia.edu/hipaa/>

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the Columbia University Medical Center Notice of Privacy Practices.

Patient Name (Print)

Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

Personal Representative (Print)

Personal Representative's Signature

Relationship

For Columbia University Medical Center use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center's Notice of Privacy Practices but was unable to for the following reason:

- Patient refused to sign
- Patient unable to sign
- Other _____

Employee Name

Date

This form should be placed in the patient's medical record