New York Gynecology Surgery

Pankaj Singhal, MD, MS, MHCM

375 E. Main Street, Suite 7, Bay Shore, NY 11706
Website: nygsurgery.com **Phone:** (631) 533 – 9733

New Patient Registration Form

Patient's Name: ______________________________ Email: ____________________

Date of Birth: ________________ Age: _____ Sex: M F Social Security #: ________________

Current Address: ______________________ City: __________ State: __________ Zip Code: ______

Home Phone #: ______________________ Employer Phone #: ________________________

Employer Name & Address: ____

Language: ____________________	Ethnicity: (Please Circle) Hispanic Non-Hispanic Unknown Race: Asian Black or African American Native Hawaiian White

Emergency Contact Name: __________________________ Relationship: ________________

Address: ____ Phone #: ____________________

Who is your referring OB Doctor?	Who is your Primary Care Doctor?

Insurance Information	
Primary Insurance: ______________________ Patient is Subscriber/Policy Holder: YES or NO	Secondary Insurance: ____________________ Patient is Subscriber/Policy Holder: YES or NO
Insured Information (If other than patient):	
Subscriber / Policy Holder: __________________________ Address: ______________________________________ SSN: __________________ DOB: __________________	Relationship to Patient: ___________ His or Her Employer: _____________

Pharmacy: __________________ Address: __________________ Phone #: __________________

Patient Signature: ______________________________________ Date: ____________________

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Patient's Name: ____ Email: ______________________

Primary OBGYN: ____________________________ Primary Care Doctor: ______________________

Past Medical History	
Past Surgical History	
Medications	
Allergies	
Obstetrical History	Pregnancies: _____ Living Children: _____ Vaginal Births: _____ C-Sections: _____ Ectopic Pregnancies: _____ Miscarriages: _____ Abortions: _____ Could you be pregnant: _____
Gynecological History	Last pap smear: _____ History of Abnormal Pap Smears: YES ____ NO ____ Last Mammogram: ____________________________ Last Menstrual Period: _________________________ Date of First Menstrual Cycle: ____________________ Personal history of sexually transmitted disease? YES ____ NO ____
Family History	Do any of the following run in your family? Breast Cancer: YES ____ NO ____ Whom? ______________ Ovarian Cancer: YES ____ NO ____ Whom? ______________ Uterine Cancer: YES ____ NO ____ Whom? ______________ Cervical Cancer: YES ____ NO ____ Whom? ______________ Colon Cancer: YES ____ NO ____ Whom? ______________

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EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access and control my Protected Health Information. I also understand that in providing treatment, submitted billing and conducting healthcare operations. New York Gynecology Surgery (NYGS) may need to disclose my protected information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit New York Gynecology Surgery (NYGS) to disclose my protected health information for the purpose of appointment / test / procedure reminders and follow-ip to the following individuals:

PLEASE LIST NAMES OF PEOPLE YOU AUTHORIZE MEDICAL INFORMATION BE RELEASED TO BELOW:

Name: ____ Relationship & Tel #: ______________________

Name: ____ Relationship & Tel #: ______________________

Name: ____ Relationship & Tel #: ______________________

Your health care is important to us.

To provide you with the best possible care, we occasionally send convenient text messages and emails to our patients about their healthcare and reminders for upcoming appointments.

Circle **YES** or **NO** to consent to Text Messages or Email appointment reminders.

I expressively permit New York Gynecology Surgery (NYGS) to disclose my health information for the purpose of appointment / test / procedure and follow-up by leaving such information in the form of a message on the following record media:

Home answering machine: ______ Tel #: ________________________

Cell phone voicemail: ______ Tel #: ________________________

Signature of Patient: ____ Date: ________________________

Personal Representative: ______________________________________

Parent / Guardian: ____

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DISCLOSURE OF HEALTH INFORMATION:

Patient's Name: ____________________________________ Date of Birth: ______________________

I authorize the following using or disclosing party: **New York Gynecology Surgery, PLLC** to use of disclose the following health information.

- All my health information
- My health information relating to the following treatment or condition:

  ____

  ____

- My health information covering from ___________ (date) to ___________ (date)
- Other: ________________________

This authorization ends: On (date) ___________

A copy of this authorization is as valid as the original.

____

Patient Name (Print):

____ _________________

Patient or Legally Authorized Representative Signature Date

____ _________________

Legally Authorized Representative (Print) Date

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security 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:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). 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 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:*

9(a). Specific information to be released:

❑ Medical Record from (insert date) ________________ to (insert date) ________________

❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

❑ Other: ______________________________

____

Include: (*Indicate by Initialing*)

________ **Alcohol/Drug Treatment**

________ **Mental Health Information**

________ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here __________ I authorize ____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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

______________________________ Date: ______________________

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**