



627 Broadway, Suite 1
 Massapequa, NY 11758
 Phone: 516-308-4040
 Fax: 516-804-6386

2171 Jericho Turnpike, Suite 304
 Commack, NY 11725
 Phone: 631-670-6525
 Fax: 631-670-6526

PATIENT REGISTRATION FORM

(Please print clearly)

Today's date: _____

Last Name _____ First Name _____ MI _____

Home Address _____
 Street City State Zip

Mailing Address if different _____
 Street City State Zip

Home Phone _____ Work Phone _____ Other/Cell Phone _____

Date of Birth _____ Age: _____ SSN: _____ Email address: _____

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other/unknown	Gender Identity: How do you see yourself? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not sure	Are You: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Decline to specify	Student Status: <input type="checkbox"/> Full time student <input type="checkbox"/> Part time student <input type="checkbox"/> Not a student
Race: <input type="checkbox"/> White <input type="checkbox"/> Black / African-American <input type="checkbox"/> Asian <input type="checkbox"/> Am. Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Decline to specify	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner <input type="checkbox"/> Other: _____	Employment Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Not employed <input type="checkbox"/> Active military <input type="checkbox"/> Retired <input type="checkbox"/> Self-employed <input type="checkbox"/> Unknown

MEDICAL INSURANCE INFORMATION

Name of Insurance _____

Member ID number _____ Group # _____

Name of Subscriber _____ Date of birth _____

Employer _____ Relationship to Patient: _____

Address of insured (if different from patient) _____
 Street City State Zip

SECONDARY INSURANCE INFORMATION

Name of Insurance _____

Member ID number _____ Group # _____

Name of Subscriber _____ Date of birth _____

Employer _____ Relationship to Patient: _____

Address of insured (if different from patient) _____
 Street City State Zip

Employment Information: Employer Name: _____

Employer Address _____
Street City State Zip

Responsible person: (if different from patient or if patient is minor)

Last Name _____ MI _____ First Name _____

Date of Birth _____ Telephone # _____

Address _____
Street City State Zip

Relationship to patient _____

Person to contact in case of emergency: Name _____

Telephone # _____ Relationship to patient _____

Reason for Visit _____

Allergies to Medication: _____

Pharmacy: _____
Name Street City Phone number

Mail Order Pharmacy: _____
Name Phone number

How did you hear about our office? _____

How can we reach you to remind you of your appointments?

Home phone Work phone Cell phone Text Message Email Other _____

Signature on File: By signing below, I

- Authorize use of this form on all on my insurance submissions.
- Authorize release of information to all of my insurance companies.
- Authorize my health care provider to act as my agent in helping obtain payment from my insurance company.
- Authorize payment directly to my healthcare provider(s): Sisselman Medical Group, P.C.,
- Permit a copy of this authorization to be used in place of the original.
- Understand that I am responsible for my bill, including any copays, deductible, or coinsurance.
- Understand that if my health care providers accept assignment, I am responsible for any amount not paid by my insurance company, which may include any non-covered services.

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

Patient Name: (print) _____

SISSelman MEDICAL GROUP, PC

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Commack, NY 11725

Tel: (631) 670-6525
Fax: (631) 670-6526

Patient Name: _____ **Date of Birth:** _____

Please fill out either section I OR section II and sign below:

Section I:

A. I, _____ give Sisselman Medical Group, PC, permission to leave information on my answering machine or with the following family member(s) or designated representative(s) as noted below:

B.

Answering Machine: _____

Family Member(s) or designated representative(s) (Please print full name and relationship.)

Please check **all** information that can be left on the above answering machine(s) and/or with the above representative(s):

- Test Results
- Lab Results
- Confirming Appointments
- Medication Changes
- Billing/Insurance Changes
- Any information pertaining to all aspects of my medical care, including all of the above.

PLEASE NOTE THAT IF YOU DO NOT CHECK OFF SECTION B, WE WILL NOT LEAVE MESSAGES.

Section II:

I, _____, do not want any information pertaining to all aspects of my medical care left on my answering machine or with anyone other than myself.

CONSENT TO TREAT A MINOR CHILD

The information I have given this office pertaining to _____ is true and complete to the best of my knowledge. I authorize the doctors and staff of Sisselman Medical Group, PC to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The doctors have implied to guarantee of cure.

Signature: _____ **Date:** _____

Relationship to patient _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices, which provides in detail the uses and disclosures of my protected health information that may be made by this practice, my rights and the practices legal duties with respect to my protected health information. I have been provided to review the Notice of Privacy Practices and understand that I can obtain a copy on request.

Signature: _____ **Date:** _____

Relationship to patient (if minor, or signed by personal representative): _____

SISSELMAN MEDICAL GROUP, PC
Stephen G. Sisselman, FACP
Jill C. Sisselman, FAACP

Date: _____

PARTICIPATING INSURANCE

I, _____ have been informed on this date _____ by Sisselman Medical Group that if my health plan does not cover routine physicals, testing done in conjunction with my physical exam, any type of surgery or any vaccines that I have been given, I (the patient) will be personally responsible for the charges incurred and in the event of non-payment, I would be responsible for any fees incurred in an attempt to collect the balance. You are ultimately responsible for knowing the requirements and coverage limitations of your own insurance policy. I understand that Sisselman Medical Group will bill my insurance company on my behalf.

Patient or Responsible Party Signature

SERVICE FEE FOR NON-CANCELLATION OF APPOINTMENT

I, _____ am aware that if I have an appointment scheduled at Sisselman Medical Group and I am unable to keep this appointment, I will be charged a service fee of \$20.00 if I do not call to cancel my appointment within 24 hours.

I understand that by not calling to cancel my appointment, I am holding an appointment in the doctor's schedule that could be used for another patient.

Patient or Responsible Party Signature

PRESCRIPTION DATABASE CONSENT FORM

I, _____ give Sisselman Medical Group permission to access RX HUB (prescription database) to view my prescription history. As of August 27, 2013, consulting the prescription database is a New York State law for both providers and pharmacists. Failure to sign this document could restrict your provider from prescribing certain controlled substances.

Patient or Responsible Party Signature

Witness

APPOINTMENT REMINDERS

In an effort to make your experience with us even more enjoyable and convenient, Sisselman Medical Group will be utilizing electronic appointment reminders. You can elect to receive text message notification, email notification or automated telephone appointment reminders.

Each of these options will allow you to confirm an appointment automatically, or prompt you to call office to reschedule.

Please select your preference below:

I would like to use the following for reminders and give my consent to do so:

Phone call #: _____ (phone number) _____ home _____ work _____ cell

Text message #: _____ (cell phone number)

Email address: _____

Signature: _____

Name: _____

SISSELMAN MEDICAL GROUP - New Patient Medical History

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Past Medical History			Today's Date:		
Condition / Disease	Year began	Condition / Disease	Year Began		
<input type="checkbox"/> Hypertension		<input type="checkbox"/> Diabetes			
<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> GERD or other digestive issues			
<input type="checkbox"/> Hypothyroidism (low thyroid)		<input type="checkbox"/> Depression or Anxiety			
<input type="checkbox"/> COPD, Emphysema or Asthma		<input type="checkbox"/> Heart Problems (specify)			
<input type="checkbox"/> Cancer (specify)		<input type="checkbox"/> Other			
Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures					
Operation / Hospitalization / Injury	Month / Yr	Operation / Hospitalization / Injury	Month / Yr		
Other Physicians and Specialists <i>List below your other physicians (i.e., Gyn, Dermatology, Orthopedic, etc.)</i>					
Medication / Food Allergies <i>List below medications or foods causing an allergic reaction (i.e., rash, swelling)</i>					
Medication / Food	Reaction	Medication / Food	Reaction		
Medications, Vitamins and Herbal Supplements					
Medication	Strength	Dosage	Medication	Strength	Dosage
<i>Example: Tylenol</i>	<i>500 mg</i>	<i>1 - twice daily</i>			
Social History					
Do you drink alcohol?		What type of alcohol?		No. of drinks per week?	
Are you a current smoker?		If you smoke, how many packs per day?			
Are you a former smoker?		If so, what year did you quit?		No. of years you smoked?	
Occupation:			Hours worked per week:		
Family Health History <i>List below the health history of your blood relatives</i>					
Relative	Current age or age at death	Health problems and age at diagnosis			
Father					
Mother					
Brother(s)					
Sister(s)					
Review of Systems <i>Please review the following symptoms, circle those items that you experience</i>					
Fever / Chills / Sweating	Chest Pain	Gallstones	Headaches	Anemia	
Fatigue / Weakness	Palpitations	Diarrhea	Numbness	Excessive hunger	
Sore Throat	Shortness of Breath	Constipation	Tingling	Excessive thirst	
Earache	Wheezing	Incontinence	Seizures / Tremor	Easy bruising	
Nasal Drip/Sinus Problems	Cough	Frequent Urination	Fainting	Breast discharge	
Hoarseness	Heartburn	Kidney Stones	Weight Loss / Gain	Lumps in breast	
Nosebleeds	Nausea	Muscle Pain	Trouble Sleeping	Heat/cold intolerance	
Hay Fever	Vomiting	Arthritis	Anxiety / Depression	Rash / Itch	
Hearing Problems	Abdominal Pain	Joint Pain / Stiffness	Bipolar		
Vision Problems	Rectal bleeding				

**SISSELMAN MEDICAL GROUP, PC
CREDIT CARD AUTHORIZATION FORM**

The purpose of this form is to authorize Sisselman Medical Group to retain a valid credit card number on file for you as our patient. All patients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information. We find it necessary to do this because of changes in health care law and changes to your health plan starting 1/1/2014.

Your supplied credit card will be charged ONLY under the following circumstances:

- To satisfy any balances more than 60 days old, including co-pays and deductibles, for claims processed by your insurance carrier. If you do not send in payment for the balance due after receiving two (2) statements from us, we will charge your credit card for the outstanding balance. We will notify you when the card will be charged.
- To pay any returned check fees (not to exceed \$35) in the event your check is returned to us for any reason.
- To pay for any Fee for Service testing, including any procedures not covered by your insurance and offered to you by us. For a list of our Fee for Service costs, please see the front desk.

A receipt will be kept in your chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current patient balances on your account. **Either sign Part 1 OR Part 2.**

PART 1: Acknowledged, Agreed & Accepted:

Having read this form and speaking to staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X _____ X _____
Patient Signature (or authorized party) Date Staff Signature Date

NAME AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

CARD# (VISA/MC): _____

EXPIRATION DATE: _____ VERIFICATION CODE (3 digits) _____

DO NOT SIGN PART 2 IF YOU SIGNED PART 1

PART 2: Refusal to Complete Authorization:

Refusal to complete and agree to this authorization dictates the following: Since there is no credit card on file with us your deductible will be due at the time of your visit. We reserve the right to send only one statement to the address on file to notify you of your balance with our practice. It is then your responsibility to send the amount due within 30 days of your statement to avoid being sent to collections and having your account closed with our practice. It is your responsibility to keep your information/demographics up to date with our office.

X _____ X _____ Patient
Signature (or authorized party) Date Staff Signature Date

**Sisselman Medical Group
Preventive Physical Exam Policy**

An annual preventive exam done at Sisselman Medical Group may include the following procedures, tests and services:

- Preventive Exam (CPT codes: 99393 - 99397 for established patients, 99383 – 99387 for new patients. For Medicare-age patients, CPT codes are G0438, G0439 or G0402.)
- Electrocardiogram (CPT code 93000)
- Spirometry or pulmonary function test (CPT 94010)
- Otoacoustic emissions or hearing test (CPT 92587)
- Provocative tests for glaucoma (CPT 92140), usually done for those over the age of 50.
- TB skin test (CPT 86580)

In addition, there are several immunizations that are recommended:

- Tetanus, diphtheria and pertussis vaccine (90715)
- Influenza vaccine (90658)
- Pneumococcal or Prevnar vaccine (90732 or 90670)

These services are done or recommended in the best interest of the patient – especially in consideration of a patient's chronic conditions, family history and medications taken. **Please understand that any of the above mentioned tests or services done with your physical exam may NOT be considered preventive by your insurance plan and therefore may apply to a copay, deductible or coinsurance and you will be billed for those fees.** If a service is simply considered not covered, we reserve the option to reduce the fee to our self-pay rate and bill the patient (usually \$25 per non-covered test; vaccines will be billed at our cost.)

It is in the patient's best interest to know his/her insurance policy and coverage guidelines as to which of these services are covered benefits, either for preventive care or for standard medical care. We try our best to check insurance eligibility and benefit information, but not all information is made available to us. Some policy provisions are not made known to us until a claim has been submitted and processed.

Please note that at the time of your wellness visit, **if you present with sick or acute complaints that are considered outside the scope of the preventive exam, an Office Visit may be charged and a balance may be due from you.**

I have read and understand that I may be financially responsible for balances due for those services performed during a preventive exam by Sisselman Medical Group.

Patient Name: _____ **DOB:** _____

Signature: _____ **Date:** _____
(If patient is minor, parent or guardian)

SISSELMAN MEDICAL GROUP, PC
Stephen G. Sisselman, D.O., F.A.C.P.
Jill Sisselman, D.O., F.A.A.F.P

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I, _____ have been informed on this date
_____ by Sisselman Medical Group that if my health plan does not cover routine
physicals, any testing performed during routine physical examination including EKG, PFT
and hearing tests, any type of surgery or any vaccines that I have been given, I will be
personally responsible for the charges incurred and in the event of non-payment, I would
be responsible for any fees incurred in an attempt to collect the balance.

I understand that Sisselman Medical Group will bill my insurance company on my behalf.

Patient or Responsible Party Signature