PATIENT INTAKE PACKAGE

2818 Ocean Avenue, Suite 1,
(Avenue X corner)
Brooklyn, NY 11235

Tel. # (718) 934-8484
Tel. # (718) 934-9595
Fax # (718) 934-4267

Today's Date: _____

Reason for visit: _____ Referred by: _____

PLEASE PRINT

PATIENT'S NAME (last, first)				
ADDRESS, CITY, STATE, ZIP				
AGE	**DATE OF BIRTH**	**SEX**	**MARITAL STATUS**	**SOCIAL SECURITY #**
		M F	**S M W D SEP**	

HOME PHONE #:	**CELLULAR PHONE #:**	**WORK PHONE #:**

Employer's Name	**Address & Title**

In case of an emergency contact:	**Telephone No.**	**Relationship**

INSURANCE INFORMATION:

Is your injury a result of an accident? **NO YES** Date of accident: _____	If **yes**, please circle what type of accident you had: Motor vehicle Worker's comp. Slip & fall
Primary Insurance Carrier:	Telephone No.:
I.D. / Claim No.	Adjuster / Case Manager:
Secondary Insurance Carrier:	Telephone No.:
I.D. / Claim No.	Group No.:
If you are being represented by an attorney, please supply us with their complete information: Name: _____ Telephone No.: _____ Address, City, State & Zip: _____	

PAGE 2: ***PLEASE PRINT ALL INFORMATION***

Height: _____ **Weight:** _____

Do you smoke? NO YES (how much?) _____

Do you consume alcohol? NO YES (how often?) _____

Please date & list all surgical procedures you have had and describe any problems that might have occurred:

_____

_____

Have you ever had a serious problem with anesthesia? ***NO*** ***YES*** ***- Please explain.***

_____

_____

Please list all allergies to medication or food: _____

Do you have a history of any of the following? (Please check)

	YES	***NO***		***YES***	***NO***
Heart Conditions			Physical limitations		
Mitral Valve Prolapse			Difficulty Walking		
Pacemaker			Hearing Impairment		
High Blood Pressure			Diabetes		
Asthma / Bronchitis			Emphysema		
Tuberculosis			Seizures		
Ulcers			HIV Positive		
Hepatitis			Other:		

Please list any and all medications, vitamins, and herbal supplements you are taking or have taken in the past 2 months:

_____

_____

Patient signature: X_____ Date: _____

CONSENTS FORM:

Patient name: _____Date: _____

ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

I hereby authorize to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependent, to the physicians. I understand that I am responsible for any amount not covered by my insurance.

I am assigning all my rights unconditionally to ***Michael Riskevich, DO & Acute & Chronic Pain Management*** to pursue any medical bills, relating to treatment or care by this office in addition to the above.

X_____
Patient signature

HIPPA PRIVACY ACKNOWLEDGEMENT

I, _____, acknowledge that I have been provided with a copy of ***Michael Riskevich, DO & Acute & Chronic Pain Management*** privacy notice. This notice is effective as of today's date.

X_____
Patient Signature

PHOTOGRAPH CONSENT

I, _____, authorize my picture be taken. I understand that my photograph will be attached to my medical chart and only used for identification purposes. I understand & do not authorize my image be used for any other purpose.

X_____
Patient Signature
( ) Declined - You may opt not have your photograph taken but must supply us with picture identification for our records.