



PATIENT INFORMATION

Patient's Legal last name:		Legal first name:	Middle:	Today's Date:	
Preferred name:			DOB:	Email:	
Street address:			SSN:	Home phone number:	
City:	State:		Zip Code:	Work phone number:	
Language Needs (Federal requirement) Would you prefer to communicate in a language other than English? (Y/N) If so, what language (including American Sign Language-ASL)? _____			Preferred Method of Contact for Appointment Confirmation:		Cell phone number:
			<input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email		Emergency Contact: Name: _____ Relationship: _____ Phone Number: _____

Insurance Information

I am insured (please provide a copy of your insurance card to the Administrative Assistant)

1. Primary Insurance Name: _____ ID#: _____

Who is the primary subscriber? (Circle) Patient/Self Spouse Parent/Guardian Other-Name _____

If other, insured date of birth: _____ Insured relationship to patient: _____

2. Secondary Insurance Name (if applicable): _____ ID#: _____

Who is the secondary subscriber? (Circle). Patient/Self Spouse Parent/Guardian Other-Name _____

If other, insured date of birth: _____ Insured relationship to patient: _____

HOW DID YOU HEAR ABOUT US?

Circle the answer that applies: Internet Radio Insurance Ad Social Media
Family Member Friend Other: _____

Referral from Healthcare Provider: Name and Address of Provider: _____

Is this Provider your PCP? Circle: Yes No If Provider listed is not your PCP, list PCP: _____

Signature

I certify that the above information is true and correct to the best of my ability.

Name of the person completing this form:

Print: _____

Relationship to Patient: _____ Signature: _____ Date: _____

GETTING TO KNOW YOU

We require the following information for the purposes of understanding our population better and to satisfy our reporting requirements to the federal government. The options for these questions were provided by those organizations which analyze this information, and in no way impacts the care you receive. Please help us serve you better by selecting the best answer to these questions. Thank you.

Race (Collected as a Federal Requirement): You may select one or more (Please Circle the Appropriate Answer):				Sex assigned at birth (Circle): Male Female	
				Marital status (Circle): Single Married Partnered/Other	
White/ Caucasian	Black or African American	Asian	Native Hawaiian	Sexual Orientation and Gender Identity (Collected as a Federal Requirement)	
American Indian/ Alaska Native	Pacific Islander	Other: _____	I decline to provide this information		
Ethnicity (Collected as a Federal Requirement). Please Circle the Appropriate Answer:				Sexual Orientation (Circle Appropriate Answer): <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else/other <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose	
Non-Hispanic	Hispanic	I decline to provide this information		Gender Identity (Select One): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Female to Male <input type="checkbox"/> Transgender Female/Male to Female <input type="checkbox"/> Gender Queer <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose	
Employment Status (Only for patients 18 years and older; Collected to assess potential exposures to health risks) Circle the Appropriate Answer:					
Employed Full-Time	Employed Part-Time	Occupation: _____			
Retired	Disabled	Student	Other	I decline to provide this information	
What is the preferred pharmacy you wish to keep on file for medications to be sent to? Pharmacy name: _____ Pharmacy Address: _____				Are you a veteran of the U.S. Military? (Circle) Yes No	
Responsible Party (Only if patient is under the age of 18 or Legal Dependent)					
Name (Last, First, Middle)		SSN	DOB	Sex	
Mailing Address			City, State, Zip		
Primary Phone			Day/Work Phone		

Acknowledgment/Authorization

I consent to examination and treatment by CVHMPC practitioners and staff.

I request that payment of authorized Medical, No-Fault or Government insurance benefits be made on my behalf to CVHMPC for services furnished to me by the provider.

I authorize the release of any medical or other information necessary to process claims.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for my balance on my account for any professional services rendered.

I have read all the information on this form and have completed the answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature of Patient: _____ **Date:** _____ / _____ / _____

Name _____

History Form - Primary Care

Date _____

Please list information in the spaces provided. Information is confidential and will not be released without your permission.

Medical History (Please check if applies)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> No Medical Conditions or chronic diseases | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Alcohol Abuse Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> IBS | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease/Kidney Stones | <input type="checkbox"/> Substance Use Disorder
What Substance(s)? _____ |
| <input type="checkbox"/> Apnea | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Please list any other medical conditions:
_____ |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Obesity | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack/Mi | <input type="checkbox"/> Osteoarthritis | _____ |
| What Kind? _____ | <input type="checkbox"/> Heart Burn/GERD | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Rheumatoid Arthritis | _____ |
| | <input type="checkbox"/> High Blood Pressure | | |

Surgical History

(Please Include Surgical Type / Reason / Date)

Health Maintenance

HPV/PAP (Z01.419) When? _____ Where? _____

Mammogram (Z12.31) When? _____ Where? _____

Colonoscopy (Z12.11) When? _____ Where? _____

Immunizations - Attach Record / Name Office & Contact Info

Family Medical History

(List Medical Condition for each Blood Relative)

Maternal Grandmother _____

Maternal Grandfather _____

Paternal Grandmother _____

Paternal Grandfather _____

Mother _____

Father _____

Sibling(s) _____

Children(s) _____

Drug / Environment / Food Allergies

(List Drug, Environment, or Food Allergies and The Type of Reaction)

Personal - Social History

Relationship Status

- Married
- Single
- Divorced
- Separated
- Domestic Partner
- Widowed

Occupation Status

- Employed
- Unemployed
- Retired
- Disabled

Occupation _____

Caffeine Use History

- Never/rarely a user
- Former user
- Current Sometime user
- Current Everyday user

What is the usual type of caffeine consumed?

Herbal Use History

- Never/rarely a user
- Former user
- Current Sometime user
- Current Everyday user

What is the usual type of herb consumed?

Smoking/Vaping History

- Smoker
- Vaper
- Never to rarely user
- Former user
- Current Sometime user
- Current Everyday user

How many Packs/Cartridges per Day? _____

How Many Years? _____

Date Stopped? _____

Alcohol Use History

- Never to rarely user
- Former User
- Current Sometimes User
- Current Everyday User

What is the usual type of alcohol consumed? _____

How Much/Often? _____

Date Stopped (if applicable) _____

Recreational Drug Use History

- Never/rarely a user
- Former user
- Current Sometime user
- Current Everyday user

What is the usual type of drug used? _____

How Much/Often? _____

Date Stopped _____

Name _____

ROS Intake Form

Date _____

Do you now or have you had any problems in the last year related to the following systems? Please check off any that applies.

<p>Constitutional Symptoms</p> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache <input type="checkbox"/> Unexplained Weight Change <input type="checkbox"/> Decreased Appetite <input type="checkbox"/> Problems Sleeping <input type="checkbox"/> Other _____	<p>Respiratory</p> <input type="checkbox"/> Dry Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough with Phlegm <input type="checkbox"/> Blood Sputum <input type="checkbox"/> Other _____	<p>Breast</p> <input type="checkbox"/> Lump <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Tenderness <input type="checkbox"/> Asymmetry <input type="checkbox"/> Dimpling <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____	<p>Psychologic</p> <input type="checkbox"/> Do you feel depressed? <input type="checkbox"/> Have you felt anxious / panicked? <input type="checkbox"/> Insomnia <input type="checkbox"/> Change in Mood <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Nightmares <input type="checkbox"/> Other _____	
<p>Eyes</p> <input type="checkbox"/> Redness <input type="checkbox"/> Pain <input type="checkbox"/> Change in Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Other _____	<p>Gastrointestinal</p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Indigestion / Heartburn <input type="checkbox"/> Bloody Stools <input type="checkbox"/> Tarry Stools <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Other _____	<p>Skin</p> <input type="checkbox"/> Rash <input type="checkbox"/> Lesion <input type="checkbox"/> Redness <input type="checkbox"/> Itchiness <input type="checkbox"/> Acne <input type="checkbox"/> Abrasion <input type="checkbox"/> Insect Bite <input type="checkbox"/> Hives <input type="checkbox"/> Other _____	<p>Endocrine</p> <input type="checkbox"/> Excessive Urination <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Tired / Sluggish <input type="checkbox"/> Other _____	
<p>Ear / Nose / Throat</p> <input type="checkbox"/> Ear Pain <input type="checkbox"/> Hearing Loss <input type="checkbox"/> High Pitch Ringing <input type="checkbox"/> Sore Throat <input type="checkbox"/> Sinus Pressure <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Runny Nose <input type="checkbox"/> Other _____	<p>Genitourinary / GYN</p> <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Testicular Pain <input type="checkbox"/> Testicular Lump <input type="checkbox"/> Dribbling with Urination <input type="checkbox"/> Urinary Urgency <input type="checkbox"/> Urinary Frequency <input type="checkbox"/> Urinary Hesitancy <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Abnormal Vaginal Bleeding <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Vaginal Oder <input type="checkbox"/> Vaginal Itching <input type="checkbox"/> Vaginal Pain <input type="checkbox"/> High Risk Sexual Activity <input type="checkbox"/> STDs <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Painful Sexual Intercourse <input type="checkbox"/> Irregular Menses <input type="checkbox"/> Painful Menstruation <input type="checkbox"/> Infertility <input type="checkbox"/> Kidney Stones <input type="checkbox"/> IUD <input type="checkbox"/> Other _____	<p>Musculoskeletal</p> <input type="checkbox"/> Joint Pain / Swelling <input type="checkbox"/> Body Aches <input type="checkbox"/> Stiffness <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Joint Popping <input type="checkbox"/> Muscle Spasm <input type="checkbox"/> Muscle Cramping <input type="checkbox"/> Neck Pain <input type="checkbox"/> Back Pain <input type="checkbox"/> Other _____	<p>Hematologic</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Swollen / Tender Lymph Nodes <input type="checkbox"/> Blood Clotting Problems <input type="checkbox"/> Other _____	
<p>Cardiovascular</p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Positional Change in Breathing <input type="checkbox"/> Swelling in Legs / Feet <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Leg Cramps When Walking? Y N <input type="checkbox"/> Other _____	<p>Extremities</p> <input type="checkbox"/> Swelling <input type="checkbox"/> Numbness/Tingling	<p>Neurological</p> <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Tremors <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Memory Loss <input type="checkbox"/> Seizures <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Change in Smell / Taste <input type="checkbox"/> Other _____	<p>Allergic / Immunologic</p> <input type="checkbox"/> Environmental Allergies <input type="checkbox"/> Difficulty Breathing due to Allergy	
<p># of Pregnancies _____ # of live births _____</p>				<p>Other: _____ _____ _____ _____ _____ _____</p>

Document Acknowledgement Form

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

By signing each statement below I acknowledge that I have received a full version of each document. I understand that this is my responsibility to read each document and ask for clarification or more information if necessary.

Document Name: By signing below you acknowledge that you are responsible for updating CVHMPC of any changes relevant to this document.	Patient Initials
Notice of Privacy Practices & HIPAA Acknowledgement: Cross Valley Health & Medicine, P.C. (CVHMPC) is committed to protecting your Personal Health Information (PHI) and stay in compliance with federal and state laws such as HIPAA. I have received a copy of the Notice of Privacy Practices and understand how my PHI may be used, as well as my rights and CVHMPC rights regarding PHI.	
Consent to Release Medical Information: I hereby give consent to the following individuals to have access and obtain copies of my medical information. This included health history, exam information, tests and lab results. Information will be provided, based on my consent below.	
Name: _____ Phone #: _____ Relationship to me: _____ Note: While authorizing the above named person to have access to your records, they are to not be authorized access to sensitive information, such as HIV Status/Information, State reportable results, and/or Alcohol and Substance Use information. If you wish to authorize access to those sensitive records, you must sign a separate consent for each at that time.	
Patient Bill of Rights and Patient Rights & Responsibilities: I have received the Patient Bill of Rights and Patient Rights & Responsibilities document.	
Assignment of Benefits: I authorize payment of insurance benefits to CVHMPC for any/all medical services provided to me. I authorize the release of medical or other information necessary to determine benefits coverage and eligibility. I understand that I am financially responsible for charges not covered by my insurance. It is my responsibility to notify CVHMPC of any changes to my health care coverage.	
Patient Portal Access: I authorize the creation and an email to be sent to my personal email to have access to my patient portal account. I understand that this email contains credentials and link that will allow unrestricted access to view my health information including diagnoses, medications, labs, HIV status and mental health and substance use related information.	
Name: _____ Email (Required): _____ Signature: _____ Date: _____	
Consent to Photograph for Electric Health Records (EHR): I give consent to CVHMPC to take my photograph to be stored in my EHR. This photograph will be used to identify me and protect me against identity theft.	

This permits Cross Valley Health & Medicine PC to allow _____, as designated below, to be present in the examination room, and I give permission to CVHMPC, its practitioners, employees and representatives, to discuss all aspects of my medical care and treatment, including, but not limited to my protected health information (PHI), and to discuss all payment issues, with such individual(s).

Patient Name (Print): _____ **Patient Signature:** _____ **Date:** _____ **Witness Employee Initials:** _____
THIS FORM DOES NOT SERVE AS A NEW YORK HEALTH PROXY OR HEALTH CARE POWER OF ATTORNEY



Patient Representative Form:

Last Name: _____ First Name: _____

Date of Birth: _____ / _____ / _____

Social Security Number: _____ - _____ - _____

Patient Information:

This permits Cross Valley Health & Medicine PC to allow _____, as designated below, to be present in the examination room, and I give permission to CVHMPC, its practitioners, employees and representatives, to discuss all aspects of my medical care and treatment, including, but not limited to my protected health information (PHI), and to discuss all payment issues, with such individual(s).

*THIS FORM DOES NOT SERVE AS A NEW YORK
HEALTH PROXY OR HEALTH CARE POWER OF ATTORNEY*

Representative Information:

Last Name: _____ First Name: _____

Date of Birth: _____ / _____ / _____

Address: _____

Telephone #: +1 (_____) _____ - _____

Relationship to the Patient: _____

*a separate authorization must be completed to share highly sensitive information, such as HIV, alcohol and substance abuse treatment, or mental health information. THIS DOES NOT GRANT THE PATIENT REPRESENTATIVE THE RIGHT TO ACCESS PRINTED MEDICAL CHARTS OR INFORMATION AND DOES NOT GIVE THEM THE RIGHT TO REQUEST THEM ON THE PATIENT'S BEHALF. In order to revoke the rights of the Patient Representative to discuss or otherwise access your PHI a revocation must be submitted to Cross Valley Health & Medicine PC.

Patient Signature: _____ Date: _____ / _____ / _____



Cancellation/Missed Appointment Policy

In order to be respectful of the health needs of other patients, please be courteous and call **845-561-7075** promptly if you are unable to show up for an appointment. If you are unable to get through to our office during office hours, you can call after hours and leave a voicemail with your cancellation.

You may also cancel your appointment through our website, www.crossvalleyhealth.com, message us through Facebook, patient portal or email us at CVHMPC@me.com. The time made available will be given to another patient. If you cancel your scheduled appointment, please contact us at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

If you do not cancel your appointment at least 24 hours prior and do not show up to your scheduled appointment, you will be charged a fee as follows:

Follow up/Sick Visit = \$25.00 Fee

Physical Exam/Specialty Procedure = \$50.00 Fee