MARK E. HOROWITZ, M.D.

DOWNTOWN FAMILY MEDICINE, P.C.
42 BROADWAY, SUITE 1530
NEW YORK, N.Y. 10004
(212) 482-2400

MIDTOWN FAMILY MEDICINE, P.C.
200 W. 57TH STREET, SUITE 1402
NEW YORK, N.Y. 10019
(212) 262-9285

PROGRESS NOTES

NAME ______________________________ DATE ____________

Phone (Business) ______________________ (Home) ______________

Reason for being here today: ______________________________

____

(OFFICE USE ONLY)

Vital Signs BP ________ P ________ R ________ T ________ LMP ________ Last Tetanus ________

____
Physicians Signature

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MEDICAL HISTORY FORM

Name ______________________ Age ________ Date of Birth ____ / ____ / ____

HISTORY

Medical illnesses: (Check if you have or have had any of the following.)

	YES	NO		YES	NO		YES	NO		YES	NO
Asthma			Emphysema			GYN Disorder			Muscular disease		
Diabetes			Seizures			Prostate disease			Skin disease		
Ulcers			Tuberculosis			Cancer			Eye disease		
Rheumatic fever			Syphilis			Arthritis			Hearing defect		
Heart disease			Abdominal disorder			Thyroid disease			Gall bladder disease		
High blood pressure			Kidney disease or stones			Nervous disorder			Other		

CURRENT MEDICATIONS	KNOWN ALLERGIES	HOSPITALIZATIONS/ OPERATIONS/FRACTURES	HISTORY IN BLOOD RELATIVES OF:
			CANCER:
			HEART ATTACK:
			HIGH BLOOD PRESSURE:
			DIABETES:
			OTHER:

Review of systems: (Check if you have any of the following.)

	YES	NO		YES	NO		YES	NO		YES	NO
Headache			Dizziness			Weight loss or gain			Swollen glands		
Blurred vision			Fainting			Palpitations			Swollen joints		
Hearing loss			Vomiting			Loss of appetite			Joint pains		
Nosebleeds			Constipation			Freq urine infection			Rash		
Chest pains			Diarrhea			Blood in urine			Muscle cramps		
Shortness of breath			Indigestion			Other urinary problems			Numbness/tingling		
Frequent cough			Blood in stools			Vaginal discharge			Back pain		
Wheezing			Black stools			Penile discharge			Sexual dysfunction		
Coughing up blood			Abdominal pain			Abnormal vaginal bleed			Other		

DO YOU SMOKE? ______ HOW MUCH? ______ DO YOU DRINK ALCOHOL? ______ HOW MUCH? ______

BLOOD TRANSFUSION? ______ LAST TETANUS SHOT? ______ FOREIGN TRAVEL IN LAST YEAR? ______ WHERE? ______

LAST PERIOD ______ / ______ / ______ # OF LIVE BIRTHS? ______ # OF PREGNANCIES ______

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT ______________________
Signature

PHYSICIAN NOTES ______________________

PHYSICAL EXAM FORM

Name ____________________ Date: ____________

Vital signs: BP ____ / ____ P ______ R ______ T ______ Height ______ Weight ______ lbs.

	NL	ABN	REMARKS			
GENERAL						
HEAD						
EYES						
FUNDOSCOPIC						
EARS						
NOSE						
MOUTH/THROAT						
NECK						
THYROID						
LYMPH NODES						
BACK						
LUNGS						
HEART						
BREASTS						
ABDOMEN						
RECTAL						
GUAIAC						
GENITALIA						
PROSTATE						
PELVIC						
VASCULAR			CAROTID	RADIAL	FEMORAL	PEDAL
NEUROLOGICAL						
SKIN						
EXTREMITIES						

ADDITIONAL REMARKS:

VISUAL ACUITY: OD ______ OS ______ OU ______

COLOR VISION ______

AUDIOLOGY SCREEN

	500	1000	2000	4000
RIGHT EAR				
LEFT EAR				

FREQUENCY (HZ)

IMPRESSION	PLAN

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FACE SHEET

DATE: ____________________

PATIENT'S NAME (Last) ______________________________ (First) ____________________

ADDRESS (Home) ____

CITY & STATE ____ ZIP CODE __________

SEX: ( ) M ( ) F AGE _____ BIRTHDATE __________ SOCIAL SECURITY # ______________

PHONE (Business) ________________ (Home) ________________ (Cell) ______________

E-MAIL ADDRESS ____

MAY WE TRANSMIT TEST RESULTS VIA E-MAIL ? YES _____ NO _____

MAY WE ADD YOUR E-MAIL ADDRESS TO OUR PATIENT MAILING LIST? YES_____ NO _____

COMPANY NAME ____

ADDRESS __________________________________ OCCUPATION __________________

CITY & STATE ______________________________________ ZIP CODE ____________

EMERGENCY CONTACT NAME ____

PHONE # ______________________________________ RELATION ________________

REASON FOR BEING HERE ____

HAVE YOU BEEN HERE BEFORE? ____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____________________________

ARE YOU ALLERGIC TO ANY MEDICATION? _________________________________

CURRENT MEDICATION ____

WOMEN: DATE OF LAST MENSTRUAL PERIOD? ____________________________

NAME OF INSURANCE CARRIER ______________________ GROUP # ______________

NAME OF POLICY HOLDER __________________________ ID# __________________

POLICY HOLDERS DATE OF BIRTH ____________________ SS# __________________

ARE YOU OR YOUR SPOUSE COVERED BY ANY OTHER MEDICAL INSURANCE? _____ YES _____ NO

IF YES, PLEASE GIVE NAME AND POLICY NUMBER _______________________________

____

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____

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http://www.familymednyc.com

Please read this page carefully and sign below
This page must be signed annually or upon any change in your insurance coverage

Our medical practice participates in most major health insurance plans. If you are a member of one of those plans, we agree to abide by the rules established by that plan, including those rules establishing fees for professional services rendered to you by one of our medical professionals. We are entitled to collect any copayments and deductibles from you at the time of your visit. We are also entitled to charge you for any product or service not covered by your plan. If you have any questions about our fees or about those products or services not covered by your plan, please ask a member of our staff. **It is your responsibility to provide us with accurate, current insurance information so our office can be paid for providing you with medical care.**

If you are a new patient, please have patience while our staff verifies your insurance coverage. You will receive an explanation of the scope and limits of your coverage and be told of any deductibles or copayments you must pay today. You will also be told of any products or services not covered by your plan. Payment for those services are expected at the time the service is rendered. We do not bill for services rendered to our patients.

It is your responsibility to tell us if you have had any change in your insurance since your last visit. If you fail to do so and our claim for payment is rejected by your old insurance company, you will be fully responsible for payment for medical services rendered today. We will not resubmit claims to a second insurance company.

Although we make our best effort to verify your insurance coverage at the time of your visit, there are times when, for whatever reason, an insurance company denies our claim for payment for services. There are several reasons this can occur: your insurance has been terminated (often through no fault of your own), a service has been rendered to you which is not covered by your plan, you have an annual deductible, etc. If this occurs, you will receive a bill from us. It is our expectation that this bill will be paid promptly. Failure to pay in a timely basis will result in our submitting your balance to our collections agency.

Please note the following additional policies:

--There is a fee of $25 for any missed appointment not cancelled at least 24 hours in advance.

--Referrals requested without an office visit are subject to an administrative fee of $15.

--There is a fee of $15 for completion of forms, including disability certifications, school and camp forms and any other form requiring physician time.

I have read and understand the above office policies about fees and insurance payment. I agree to be fully responsible for any fees for professional services rendered to me that are not covered by my insurance, including, but not limited to, copayments, deductibles and excluded services.

____

Signed

____

Name Printed

____

Date

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Acknowledgment of Privacy Practices

We are required by law to protect the privacy of health information that may reveal your identity. We are also required to have available to all patients a notice of privacy practices adopted by this medical practice. A copy of that notice is always available for your inspection. You should ask a member of our staff for that notice and should read it.

"I have read the notice of privacy practices adopted by Downtown Family Medicine, PC. I understand those practices. I have had the opportunity to ask questions about those policies."

____

Signed

____

Name Printed

____

Date

"I am aware that a notice of privacy practices is available in the waiting area of this medical practice. I decline my opportunity to review those policies. I know that I can review those policies at any time."

____

Signed

____

Name Printed

____

Date

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Individual Authorization for Reporting of Diagnostic Test Results

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of that commitment, we must obtain your written authorization to disclose to you the results of diagnostic tests you have had in our office or in facilities to which we refer you. In addition, we must obtain your consent to transmit medical information about you to other health care practitioners or hospitals, should the need arise. This form provides that authorization and helps us make sure that you are properly informed of how that information will be disclosed. Please read the information below carefully before indication how we should report test results to you.

Our doctors are committed to reporting test results to you in a timely fashion. As you consider the options below, please bear in mind that our doctors balance multiple responsibilities during the course of their work day. Therefore, we ask you NOT to call the office for results of tests UNLESS you are returning a message from a doctor who has tried to reach you with test results.

If you have any questions about the content of this form, please ask a member of our staff. Please indicate acceptable method(s) we may use to report test results to you by initialing the space next to that method. You should read the privacy limitations of each method carefully before initialing that method. Finally, you should sign your complete name at the bottom of the form. If your test results are abnormal, we will usually try to reach you by telephone, to avoid delay in reporting. We prefer not to email abnormal test results.

1. Notification by telephone

____If you choose this method, test results will be delivered to you by telephone. Our doctors will call you from a private location, where others, including patients and staff, cannot hear information being given to you. The privacy of this method is limited by the fact that some patients may not have completely private telephone lines.

2. Notification by Mail

____We can notify you of test results by mailing you a post card, sealed with a staple, describing your results. The privacy of this method is limited if others have access to your mail.

3. **Notification by Email**

_____We can notify you of test results by email. We are unable to encrypt email. In addition, some individuals share computer terminals with others and may share email accounts or others may have access to your email. A variety of other limitations may result in your email being accessible to others.

If you choose this method, please provide your current email address:

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4. **Notification in person**

_____We can give you your test results in person, in the privacy of our office. There is no privacy concern with this method, but delays in reporting test results in this way are unavoidable, as the waiting time for an appointment can be days or even weeks. If you choose this method, your office visit will be subject to all the usual fees and copayments.

I have read the above descriptions of methods available for reporting test results to me. I understand the privacy limitations of each and have made my choice(s) by initialing the space next to the method(s) I have chosen.

____

Signed

____

Printed Name

____

Date

I also authorize Downtown Family Medicine, PC and its personnel to mail or fax my confidential health information to other health care facilities or practitioners, as needed, to assist in providing me with health care services.

____

Signed