CLARKSTOWN MEDICAL CARE, P.C.
JAMES SAYEGH, M.D.

Welcome to the office of Dr. Sayegh. Please allow receptionist to copy/record all insurance cards. Thank you 7/1/2019

Date:	Patient Last Name, First Name & Middle Initial	Date of Birth	Age	Social Security Number

Patient Mailing Address

Town State Zip code:

Patient Home Phone Number	Patient Work Number	Patient Cell:
( )	( ) Ext.	( )

Please indicate preferred contact number:	Patient is:	Occupation:
☐ Home ☐ Work ☐ Cell	☐ Employed ☐ Retired	

Patient Sex:	Patient email:
☐ Male ☐ Female	

Race:
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ White ☐ Other ☐ Unknown ☐ Prefer not to answer

Ethnicity:	Preferred Language:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other ☐ Prefer not to answer	☐ English ☐ Spanish ☐ Other

Patient is:	Spouse Name:		Patient Relationship to Insured:
☐ Single ☐ Married ☐ Widowed ☐ Other			☐ Self ☐ Spouse ☐ Child ☐ Other
Name of **Primary** Insurance Carrier	Member ID Number		Group Number
Policy Holder Name on Primary Plan	Policy Holder Birth Date	PCP Copay	PCP Selection Required? If yes, selected? ☐ Yes ☐ No
Name of **Secondary** Insurance Carrier	Member ID Number		Group Number
Policy Holder Name on Secondary Plan	Policy Holder Birth Date	PCP Copay	PCP Selection Required? If yes, selected? ☐ Yes ☐ No

Previous Primary Care Physician	Address

Emergency Contact	Telephone Number	Relationship

CLARKSTOWN MEDICAL CARE, P.C. - PF-3000 (b) Notice of Privacy Practices Acknowledgement

We keep a record of the health care services provided to you. You may ask to see & copy records. You may also ask to correct records. We will not disclose your records to others unless you direct us to do so or unless the law authorizes/compels us to do so. You may see your records or get more info by contacting the administrator. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Print Patient Name:______________________________ MRN Number:__________

Patient or Legally authorized individual signature ______________________ Date__________ Time:__________

Printed Name if signed on behalf of Patient:______________________ Relationship to Patient__________

I authorize Clarkstown Medical Care, P.C. to send/leave messages at my home, via writing and voice regarding my medical care.

Patient/Guardian Signature______________________________ Date__________ Time__________

Authorization for persons/organization(s) to whom information may be disclosed:

Print Name:______________________ Tel:______________ Relationship to Patient:__________

Print Name:______________________ Tel:______________ Relationship to Patient:__________

CLARKSTOWN MEDICAL CARE, P.C. FINANCIAL AGREEMENT & OFFICE POLICY

- I authorize the release of information necessary to *any and all* entities to secure the payment of benefits submitted for services rendered by Clarkstown Medical Care, P.C. on behalf of myself and/or dependents. I understand information will be provided to a contracted billing service, Advanced Electronic Medical Billing, Inc., to secure the payment of benefits. I further agree that my signature on this document authorizes all claims to be submitted for benefits for all services rendered without obtaining my signature for each claim. I assign directly to Clarkstown Medical Care, P.C. payments for all services rendered. I also authorize Clarkstown Medical Care, P.C. and Advanced Electronic Medical Billing, Inc., to file a complaint on my behalf for any dispute or appeal regarding accurate and fair reimbursement for services rendered.

- **I understand I am financially and fully responsible for all charges if my insurance carrier denies payment for any reason.** I understand I am responsible for any deductibles, coinsurance or copays according to my benefit plan. I understand copays and all balances on account are due at the time of visit. I understand that a delinquent balance must be paid in full prior to any scheduled appointments, unless prior payment plans are made. I agree to provide Clarkstown Medical Care, P.C. with current insurance and provide changes within 30 days from service.

- I understand I must contact my insurance company prior to services rendered, to determine if the provider participates with my specific plan, comply with Primary Care Selection requirements, determine referral or pre-authorization needs, and understand coverage limits. I understand I am responsible for claims denied due to my failure to comply with insurance plan policy. In the event my insurance carrier issues a payment directly to me, I agree to pay Clarkstown Medical Care, P.C., the same amount plus any co-pays, deductibles or coinsurances due. I agree to send in payment along with the explanation of benefits upon receipt of payment. Credit balances will remain on file and applied to future balances unless a refund is requested in writing.

- I understand that payment is due upon receipt of my monthly statement. I understand that I will be legally responsible for any and all collection and attorney fees on all balances due necessary for the collection of payment, in addition to any returned check fees.

- An appointment time has been allocated to you, and not available for other patients. We require 24 hours advance notice of all cancellations. A charge of $30.00 will be incurred if not cancelled within 24 hours advance notice. Reminders calls are a courtesy, it is your responsibility to remember your appointment.

- Telephone prescription refills must be requested Monday-Friday between 8:30 and 4:00pm. Please allow 24-48 hours for your order to be called in. Telephone refills may be delayed due to the need for the physician to review your record. It is our belief that narcotic pain relievers are in general for short term use only. Likewise, prescriptions will not be called in after hours and on weekends.

- The clinic staff at Clarkstown Medical Care, P.C will return patient phone calls received before 4:30 pm Monday - Friday before the clinic closes that day. Calls received after this time will be returned the next business day. If you require urgent attention, proceed to the nearest hospital emergency room or call 911.

- Consent for treatment: I authorize Clarkstown Medical Care, P.C. to furnish any and all medical and/or surgical treatment of those mentioned, considered necessary & proper in the treatment of the patient identified below while a patient at Clarkstown Medical Care, P.C. This treatment may require but is not limited to, diagnostic procedures, lab testing, blood draw, CT Scans, Ultrasounds, and Urodynamics.

My signature indicates my understanding & acceptance. This agreement has no term date and will remain in force until such time as a new agreement is signed.

Patient or Guarantor Signature (Must be 18 Years of Age)	Date	Relationship to Patient
Financial guarantor name		
Financial Guarantor Date of Birth	**Guarantor Social Security#**	**Guarantor Tel**
Guarantor full address		

CLARKSTOWN MEDICAL CARE, P.C.

JAMES SAYEGH, M.D.
301 N. MAIN ST. SUITE 2 NEW CITY, N.Y. 10956-4021 TEL. (845) 638-0400 FAX. (845) 638-1193

NEW PATIENT HISTORY FORM

Today's Date:

Patient Last Name, First Name & Middle Initial	Date of Birth	Age	Social Security Number

Patient Mailing Address

Town State Zip code:

Patient Home Phone Number	Patient Work Number	Patient Cell:
( )	( ) Ext.	( )

Please indicate preferred number:	Patient Sex:	Referring Physician Name:	Primary Care Physician:
☐ Home ☐ Work ☐ Cell	☐ M ☐ F		

Reason for today's visit:

Answers on this form will help our health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess.

PERSONAL MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems. Indicate with a Yes or No

Yes	No		Yes	No	
		Heart Disease: (type)			Kidney Disease
		High Blood Pressure			Kidney Stones
		High Cholesterol			Hepatitis __ A __ B __ C
		Diabetes __ Type 1 or __ Type II			Gastrointestinal Disease
		Thyroid Problem			Cancer (type): Oncologist:
		Gout			Back/Spinal Cord Injury
		Asthma/Lung Disease			Glaucoma

Has it been recommended that you take antibiotics prior to dental or other procedures: __ Yes __ No

SEXUAL HISTORY:

Active: __ Yes __ No Libido: __ Normal __ Diminished Contraception Method:

Sexually Transmitted Disease: __ Yes __ No Type:

SURGICAL HISTORY:

Type of Surgery	Date of Surgery	Age at Surgery

MEDICATIONS:

Name	Dosage	Frequency

ALLERGIES:

Allergies: __ Yes __ No Type:

FAMILY HISTORY

Please indicate yes or no, if your grandparents, parents, or brothers/sisters have had the following conditions

Yes	No		Yes	No	
		Kidney Cancer			Kidney Disease
		Bladder Cancer			Kidney Stones
		Prostate Cancer			High Cholesterol
		Diabetes			Gout
		Heart Disease			Stroke
		Heart Attack			High Blood Pressure
		Cancer Type:			

SOCIAL HISTORY

Cigarettes: _____Packs/day ____# of Years ___ Never ___ Quit

Alcohol Use: Do you drink Alcohol? Yes No # of drinks per week

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NEW PATIENT HISTORY FORM Today's Date:

Please indicate number of children if here for a Vasectomy Consult:

REVIEW OF SYMPTOMS

Please check any CURRENT symptoms you have.

GENERAL

___ Recent fevers/sweats
___ Change in appetite
___ Headaches
___ Chills
___ Unexplained fatigue
___ Unexplained weight loss
___ Sleeping Difficulty

SKIN

___ Rash
___ Non-healing lesions

EYES/EARS/NOSE/THROAT/MOUTH

___ Glaucoma
___ Blurring or double vision
___ Cataracts
___ Glasses/Contacts
___ Ear pain
___ Hay fever
___ Allergies
___ Congestion
___ Persistent sore throat
___ Difficulty hearing
___ Ringing in ears
___ Trouble swallowing

RESPIRATORY

___ Asthma
___ Chronic Obstructive Pulmonary Disease –COPD
___ Tuberculosis
___ Cough/wheeze
___ Coughing up blood
___ Shortness of breath
___ Emphysema

CARDIOVASCULAR

___ Chest pain
___ Shortness of breath with exertion
___ Heart murmur
___ Palpitations
___ Swelling in extremities
___ Pacemaker/Defibrillator
___ Heart Attacks
___ Stroke
___ Valve replacement

GASTROINTESTINAL

___ Abdominal pain
___ Change in appetite
___ Nausea
___ Diarrhea
___ Constipation
___ Vomiting

GENITOURINARY

___ Painful urination
___ Bloody urination
___ Discharge: ___ penis ___ vagina
___ Leakage of urine _____ # pads used per day
___ Nighttime urination _____ # of times
___ Difficulty emptying bladder completely
___ Recent urinary tract infections
___ Recent prostate infections
___ Recent kidney infections
___ Concern with sexual function

MUSCULOSKELETAL

___ Muscle pain
___ Chronic back pain
___ Joint pain
___ Recent back pain

NEUROLOGICAL

___ Weakness in any part of your body
___ Recent loss of consciousness
___ Loss of energy
___ Dizzy spells
___ Numbness in any part of your body
___ Memory loss
___ Seizures or convulsions
___ Confusion

PSYCHIATRIC

___ Anxiety
___ Stress
___ Depression
___ Sleep problems
___ Other

ENDOCRINE

___ Excessive thirst
___ Excessive hunger
___ Heat Intolerance
___ Thyroid problems

HEMATOLOGIC/LYMPHATIC

___ Anemia
___ Easy bruising/bleeding
___ Unexplained lumps

Comments:

Patient or Guardian signature: Date:

Provider signature: Date:

Date updated/Reviewed: