PATIENT NAME:_____ **DATE OF BIRTH:**_____

ADDRESS: _____

CITY, STATE:_____ **ZIP CODE:**_____

TELEPHONE NUMBERS-HOME:_____**WORK:** _____**CELL:** _____

E-MAIL ADDRESS:_____

SOCIAL SECURITY NUMBER:_____

INSURANCE COMPANY:_____ **NAME OF INSURED (IF DIFFERENT):**_____

RELATIONSHIP TO INSURED:_____ **DATE OF BIRTH OF INSURED:**_____

EMERGENCY CONTACT NAME AND TELEPHONE NUMBER:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the above referenced practitioners to furnish information to insurance carriers concerning my illness and treatment and I assign to the practitioners all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____

PATIENT'S SIGNATURE **DATE**

PATIENT'S FORMS:

I hereby acknowledge that I was given an opportunity to review the following forms for the practice:

Medical Home Description	Sleep Screening
Financial Policies	Vaccine Policy
Office Policies	Documentation Preparation Fees
Physician Participation and Affiliation Information	Referrals to Other Providers
Credit Card Policy	

MEDICAL HISTORY AND CURRENT MEDICATION UPDATE:

The following information regarding my medical history and current medications should be added to my chart:

_____

_____ _____

PATIENT'S SIGNATURE **DATE**

HEATH MAINTENANCE RECORD			
When was your last … (please provide the year)			
Physical Exam		**Female Patients**	
Colonoscopy		Pap Smear	
Gastroenterologist's Name		Last Menstrual Period	
Cardiac Workup		Breast Examination	
Cardiologist's Name		Mammogram	
Eye Exam		Bone Density	
Ophthalmologist's Name		*OB/GYN's Name*	
Chest X-ray			
Male Patients			
Prostate Specific Antigen (PSA)			
Urologist's Name			
Have you fallen within the last year? ❑ YES ❑ NO **If yes, how many times:**			

VACCINE RECORD			
Name of Vaccine	**Year of Last Dose**	**Name of Vaccine**	**Year of Last Dose**
Flu Vaccine		Pneumonia Vaccine	
Covid-19 Vaccine		Other Vaccines	

ADVANCED HEALTHCARE DIRECTIVE:

Do you have an ADVANCED HEALTHCARE DIRECTIVE? (a legal document in which a you specify what actions should be taken for your health if you are no longer able to make decisions for yourself because of illness or incapacity)

- Health Care Proxy
- Living Will
- Other: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA"):

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read, if I so choose) and understood the Notice. I also acknowledge that Dr. Scafuri & Associates uses a HIPAA Compliant and secure virtual remote scribe which allows them to complete their medical charts more quickly and efficiently and focus more on me. If I have any questions about their remote scribe, I agree to let them know. The following is a list of the names of people who I wish to receive my medical information which includes test results:

_____

_____ _____

PATIENT'S SIGNATURE **DATE**

UPDATED CREDIT CARD:

Name on Card: _____ Card Number: _____

Visa _____ Master Card _____ Amex _____ Discover _____

3-4 Digit Security Code: _____ Billing Zip Code: _____ Expiration Date: _____

_____ _____

PATIENT'S SIGNATURE **DATE**