

MICHAEL R. DOURMASHKIN, M.D.
DIVISION OF INTEGRATED MEDICAL PROFESSIONALS
Patient Demographics & Insurance Information

Date: _____

Last Name: _____ First: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Birthdate: ___/___/___ Status: _____ Sex: Male ___ Female ___

Social Security: _____ Occupation: _____

Referred By: _____ Phone: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Pharmacy Name: _____ Phone: _____ Fax: _____

Primary Physician: _____ UPIN # _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

PRIMARY CARRIER: _____

Address: _____ City: _____ State: _____

Policy #: _____ Group#: _____

Subscriber Name: _____ Relationship: _____

Subscriber SS#: _____ Date of Birth: _____

Secondary Carrier: _____

Address: _____ City: _____ State: _____

Policy #: _____ Group#: _____

Subscriber Name: _____ Relationship: _____

Subscriber SS#: _____ Date of Birth: _____

**** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Michael R. Dourmashkin, M.D. for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services and its agents any information needed to determine those benefits or the benefits payable for related services****

Patient Signature

Date

Authorization To Use And Disclose Health Information

(Note: This form can not be used to authorize a release of HIV- related information)

Patient Name: _____

Last

First

Middle

Home Address: _____

Specify Information And Recipient To Be Disclosed: _____

By my signature below, I hereby authorize the practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s) ("At the request of the patient" is sufficient if the patient is initiating this Authorization):

I understand that once the practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization, the practice cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information

I understand that the practice will directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at anytime) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the practice's treatment of me; except, however, if my treatment at the practice is for the sole purpose of creating PHI for disclosure to the recipient identified in this Authorization, in which case the practice may refuse to treat me if I do not sign this Authorization. If my treatment is related to my participation in a research study, I understand that the practice may refuse to treat me if I do not sign this Authorization," and (2) the patient would be permitted to designate an expiration date/event of "none.

I understand my Authorization will remain in effect until the term of Authorization expires or I prove a written notice of revocation to the practice's Office Manager at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the practice in reliance of this Authorization before it received my written notice of revocation.

The address of the practice's Office Manager is: **372 Post Ave. Westbury NY 11590** and I may contact the Office Manager by telephone at: **516-334-8400**

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information: I hereby, knowingly and voluntarily, authorize the practice to use or disclose my health information in the manner described above.

Signature of patient

Date

PATIENT HISTORY FORM

Today's Date ___/___/___

Date of Birth ___/___/___

Last Name _____ First Name _____ Middle _____

Chief Complaint What is the reason for your visit today? (Describe your problem)

History of Present Illness

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| <p>Location of problem Abdomen Back/Kidney Bladder Genitals Urine Infertility Other _____</p> <p>On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem? 1 2 3 4 5 6 7 8 9 10</p> <p>When did you first notice the problem? 2 days ago 2 weeks ago 1 month ago Other _____</p> <p>Does anything help or make the problem worse? Moving around Lifting / Straining Eating / Drinking Other _____</p> | <p>How long does the problem last? 30 minutes 1 hour It is always there</p> <p>Is anything else occurring at the same time? Yes No Nausea/Vomiting Fever / Chills Diarrhea Other _____</p> <p>Is there pain? Yes No (If yes, please describe) Dull Sharp Comes and goes Always there Other _____</p> <p>Does the problem interfere with your normal functions? Yes No (If yes, please explain) _____</p> |
|---|--|

Past Medical History

| | |
|---|---|
| <p>List all past or present medical problems</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List any past Surgeries and when they occurred</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p>List any medication, herbs or supplements you take</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Do you have any allergies? Yes No (If yes, please explain)</p> <p>_____</p> <p>_____</p> |
|---|---|

Social History & Family History

| | |
|--|---|
| <p>Do you smoke? Yes No If yes, how much? _____ How long? _____</p> <p>Do you Drink? Yes No If yes, How Much? _____</p> <p>Are you on a special diet? Yes No (If yes, please explain)</p> <p>_____</p> | <p>List all the medical problems in your immediate family</p> <p><input type="checkbox"/> Family history of Prostate Cancer</p> <p><input type="checkbox"/> Family history of Kidney Cancer</p> <p><input type="checkbox"/> Family history of Kidney Stones</p> <p><input type="checkbox"/> Family history of Breast Cancer</p> <p><input type="checkbox"/> Family history of Colon Cancer</p> <p>_____</p> |
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Review of Systems

Do you now or have you had any problems related to the following systems? Please check box
 You may explain any positive answers in the space provided

| | |
|--|---|
| <p>Constitutional Symptoms</p> <p>Chills <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Fever <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Fatigue <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other _____</p> <p>Skin</p> <p>Bruising <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Persistent itch <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Skin rash <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other _____</p> <p>Head/Ear/Eye/Nose/Throat</p> <p>Headache <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Ringling in the ear <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Nasal congestion <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other _____</p> <p>Respiratory</p> <p>Frequent cough <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Wheezing <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Shortness of breath <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other _____</p> <p>Cardiovascular</p> <p>Chest pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>High blood pressure <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other _____</p> <p>Gastrointestinal</p> <p>Abdominal pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Constipation <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Nausea/vomiting <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other _____</p> <p>Musculoskeletal</p> <p>Back pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Joint pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Muscle pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other _____</p> <p>Neurologic</p> <p>Dizzy Spells <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Seizures <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Weakness <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other _____</p> <p>Endocrine</p> <p>Appetite changes <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Excessive thirst <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Appetite changes <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other _____</p> <p>Hematological/Lymphatic</p> <p>Blood clotting problems <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Swollen glands <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Excessive bleeding <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Other _____</p> | <p>Male GU History</p> <p><input type="checkbox"/> Hematuria</p> <p><input type="checkbox"/> Change in urinary stream</p> <p><input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> Flank Pain</p> <p><input type="checkbox"/> Urinary frequency</p> <p><input type="checkbox"/> Urinary hesitency</p> <p><input type="checkbox"/> Erection problems</p> <p><input type="checkbox"/> Incomplete bladder emptying</p> <p><input type="checkbox"/> Urinary incontinence (Loss of Urine)</p> <p><input type="checkbox"/> Penile lesions</p> <p><input type="checkbox"/> Testicular mass</p> <p><input type="checkbox"/> Testicular pain</p> <p><input type="checkbox"/> Urethral (Penile) discharge</p> <p><input type="checkbox"/> Urinary urgency</p> <p><input type="checkbox"/> urination at night</p> <p><input type="checkbox"/> IPSS score _____</p> <p>Other _____</p> <p>Female GU History</p> <p><input type="checkbox"/> Absence of Menstruation</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Change in bladder habits</p> <p><input type="checkbox"/> Flank pain</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Incomplete bladder emptying</p> <p><input type="checkbox"/> Incontinence (Loss of Urine)</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Urinary urgency</p> <p><input type="checkbox"/> Urination at night</p> <p><input type="checkbox"/> It is possible that I am pregnant</p> <p>Other _____</p> |
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If you need to add additional information please do so below:
