ANDREW H. KRINSKY, MD., LLC

New/Update PATIENT FORM
(Please Print Clearly)

PATIENT NAME:______________________________ DATE:__________________

ADDRESS: ____

CITY: ____________________ STATE: _________ ZIP: ____________________

RACE: ______________ ETHNICITY____________ DOB: ____________ SEX (circle one): M F

HOME PHONE: ________________________ CELL: __________________________
(please circle your preferred phone #)

EMAIL ADDRESS:____

MARITAL STATUS (circle one): S M W D REFERRED BY: ________________________

EMPLOYER: ____

ADDRESS: __________________________________ PHONE: __________________

SPOUSE: ____

SPOUSE EMPLOYER: ____

ADDRESS: _________________________________ PHONE __________________

PRIMARY LANGUAGE SPOKEN:______________ DO YOU NEED A TRANSLATOR?: YES___ NO___

IN CASE OF EMERGENCY: ___________________________ PHONE:________________

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU: ___________________________

PHONE: ____

PHARMACY NAME& NUMBER: ____

IF OVER 18, DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?: YES_____ NO_____

IF NO, WOULD YOU LIKE INFORMATION CONCERNING YOUR RIGHTS REGARDING ADVANCE DIRECTIVES?: YES_____ NO_____

INSURANCE NAME:_____________________________ ID #:______________________

GROUP #:______________________ PHONE:______________________________

INSURANCE POLICY HOLDER: ____

POLICY HOLDER ID#: __________________________ DOB: ____________________

RELATIONSHIP: ____________________________ PHONE: ____________________

Revised 01/05/20

Notice of Malpractice Insurance, No Show Appointments & Assignment of Benefits

A: I hereby assign all medical and or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Andrew H. Krinsky LLC, Inc.

B: **I understand that I am financially responsible for all charges not paid by said insurance. I hereby authorize said Assignor to release all information necessary to secure payment.**

C: **I understand it is my responsibility to know what my insurance coverage is, if I am responsible for any deductible, co-ins or copay.**

D: **EVEN THOUGH WE MAY HAVE CONTACTED YOUR INSURANCE COMPANY TO VERIFY YOUR COVERAGE, IT IS NOT A GUARANTEE OF PAYMENT.**

E: Payments **MUST** be made at the time of each visit, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I understand Andrew H. Krinsky LLC, Inc. reserves the right to charge an administrative fee of $15.00 for any deductible, co-ins or copay not paid at the time of service. A surcharge of 35% will be added to any accounts sent to our collection department.

F: We confirm appointments as a courtesy through a third party vendor. Via text, call or email. It is your RESPONSIBILITY to be aware of the time and date.

G: I understand that I will be charged a $25.00 fee for any no show appointments or cancellations without 24 hour prior notice.

H: I understand that as of 03/01/05 Dr Krinsky does not carry medical malpractice insurance.

I. Dr. Krinsky's practice primarily consists of office gynecology and minor outpatient surgery. Should you need hospitalization or major surgery Dr. Krinsky will provide you with an appropriate referral.

J. If you are going to be more the 10 minutes late for your appointment, we ask that you make a courtesy call informing the office. If you are more then 20 minutes late for your appointment depending on how the schedule is running, you may be asked to reschedule your appointment.

K. I understand that it may be necessary for Dr. Krinsky to perform certain lab tests during my visit that may not be covered by my insurance company. In that event I understand I will be responsible for the charge upon check-out.

I HAVE READ AND UNDERSTAND THE ABOVE

Signed by: ______________________________ DATE: ____________________

I herby authorize my medical information and/or results to be discussed with anyone listed below.

Signed by: ______________________________ DATE: ____________________

Name________________________________DOB______________DATE ______________

Heart Disease is the leading cause of death & disability among women in the United States. Get your Heart Wellness Assessment today. This 3-minute non-invasive test can be taken today and your healthcare provider will provide you with immediate results on the health of your heart.

Please check off all boxes that apply to you and return to the front desk when completed.

It's time to be proactive – Prevention saves lives

	Dizziness, Trouble w Balance coordination		Family History of Heart Disease
	Fainting/Blackout		BMI 30 or Higher
	Tingling, Burning Sensations		Hypertension
	Diabetic		Anxiety, Apprehensiveness
	Incontinence		Depression
	Sexual Dysfunction		Peripheral Artery Disease
	Muscle Weakness		High Cholesterol
	Cramps		Pain in Limb
	Nausea, Vomiting, Diarrhea, Constipation		Migraines / Headaches
	Disorders of the Autonomic Nervous System		Dyslipidemia or Fatty Arteries
	Fracture or Dislocated bones		Periodontal Disease
	Hypoglycemia		Family History of CVD
	Abnormal Sweating		Fibromyalgia
	Rheum Arthritis/Poor Kidney Function		General Numbness
	Abnormal Heart Rate or BP		(PTSD) Post Traumatic Stress Syndrome
	Nerve Entrapment		Bipolar Disorder
	Polycystic Ovary Syndrome		Persistent Pain
	Low Libido		Depressive Disorder
	Varicose Veins		Premenstrual Syndrome
	Cigarette Smoker/Tobacco use		Taking Birth Control
	Asthma		Taking Hormones for Aging
	Irritable bowel		Bio Identical Hormone Therapy
	Sleep Disorder		Family History of Diabetes
	Alcohol Use		Steroid Use
	Drug Use		Chronic Fatigue Syndrome
	Deep Vein Thrombosis		Annual GYN Exam

ANDREW H. KRIN~Y, M.D., F.A.C.O.G, LLC

GYNECOLOGY

NAME

AGE

OCCUPATION

S.M.D. SEP

FAMILY HISTORY	LIVING AGE	LIVING HEALTH	DECEASED AGE	DECEASED HEALTH
FATHER				
MOTHER				
BROTHER OR SISTER 1				
2				
3				
4				
5				
HUSBAND				
SON OR DAUGHTER 1				
2				
3				
4				
5				

Has any relative ever had	NO	YES	WHO
CANCER	☐	☐	
TUBERCULOSIS	☐	☐	
DIABETES	☐	☐	
HEART TROUBLE	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	
STROKE	☐	☐	
EPILEPSY	☐	☐	
SUICIDE	☐	☐	
MENTAL ILLNESS	☐	☐	
HYSTEREOTOMY	☐	☐	
CESAREAN SECTION	☐	☐	
KIDNEY TROUBLE	☐	☐	

MENSTRUAL HISTORY

AGE AT ONSET ________

REGULAR ☐ YES ☐ NO

CYCLE ________ DAYS (FROM START TO START)

USUAL DURATION ________ DAYS

FLOW ☐ LIGHT ☐ MED ☐ HEAVY

PAINS OR CRAMPS ☐ YES ☐ NO

DATE OF LAST PERIOD ________

LIST PREGNANCIES (INCLUDING MISCARRIAGES)

YEAR	WEIGHT	SEX	HRS OF LABOR	ANESTHESIA	COMPLICATIONS

PERSONAL HISTORY

WEIGHT NOW ________ 1 YEAR AGO ________ HIGHEST ________ WHEN ________

HAVE YOU EVER HAD	NO	YES
GERMAN MEASLER	☐	☐
MUMPS	☐	☐
CHICKEN POX	☐	☐
SCARLET FEVER	☐	☐
DIPTHERIA	☐	☐
PNEUMONIA	☐	☐
RHEUMATIC FEVER	☐	☐
HEART DISEASE	☐	☐
HEART MURMUR	☐	☐
POLIO OR MENINGITIS	☐	☐
KIDNEY INFECTIONS	☐	☐
GONORRHEA OR SYPHILIS	☐	☐
ANEMIA	☐	☐
JUANDICE	☐	☐
GALLBLADDER DISEASE	☐	☐
EPILEPSY	☐	☐
MIRRAINE HEADACHES	☐	☐
TUBERCULOSIS	☐	☐
VALLEY FEVER	☐	☐
CANCER	☐	☐
HIGH OR LOW BLOOD PRESSURE	☐	☐
NERVOUS BREAKDOWN	☐	☐

DO YOU NOW HAVE OR HAVE EVER HAD	YES	NO
ANY EYE DISEASE, INJURY, IMPAIRED SIGH	☐	☐
ANY EAR DISEASE, INJURY, IMPAIRED HEAF	☐	☐
ANY TROUBLE WITH NOSE, SINUSES, MOUT	☐	☐
ANY HEAD INJURY, FAINTING SPELLS, CON\	☐	☐
FREQUENT OR SEVERE HEADACHES	☐	☐
SKIN DISEASE	☐	☐
CHRONIC OR FREQUENT COUGH	☐	☐
CHEST PAIN, SPITTING UP BLOOD	☐	☐
NIGHT SWEATS	☐	☐
SHORTNESS OF BREATH	☐	☐
SWELLING OF HANDS, FEET, OR ANKLES	☐	☐
VARICOSE VEINS	☐	☐
KIDNEY OR BLADDER DISEASE	☐	☐
INDIGESTION, STOMACH TROUBLE, OR ULC	☐	☐
RECTAL BLEEDING, CONSTIPATION OR DIAI	☐	☐
LOSS OF URINE WITH COUGH OR SNEEZE	☐	☐

ALCOHOLIC BEVERAGE ☐ NEVER ☐ MOD ☐ DAILY

CIGARETTES ________ PACKS PER DAY

SURGERY - (IF YES, WHAT, WHEN, WHERE)

____

ALLERGIES ________

TRANSFUSIONS - (IF YES, NUMBER) ________

WHAT MEDICINES ARE YOU NOW ON: ________

Family History Questionnaire For Hereditary Cancer Syndromes

Select the condition(s) that apply below and fill out the corresponding information

Breast and Ovarian Cancer	Patient	Immediate Blood Relatives		Extended Blood Relatives (Aunts, Uncles, Grandparents, etc.)			
	Age at Diagnosis	Parents, Siblings or Children	Age at Diagnosis	Mother's Side	Age at Diagnosis	Father's Side	Age at Diagnosis
Example: Female relative with Breast Cancer at age ≤ 50	45	Mother Sister	49 36	Maternal Aunt	46	Paternal First Cousin	50
☐ Female relative with Breast Cancer at age ≤ 50							
☐ Female relative with Breast Cancer > 50							
☐ "Triple Negative" Breast Cancer (Estrogen Receptor (ER) negative, Progesterone Receptor (PR) negative, HER2neu negative)							
☐ Ovarian, fallopian tube, or primary peritoneal cancer							
☐ A female relative who has been diagnosed with both breast and ovarian cancer in her lifetime (two separate cancers)							
☐ Male breast cancer							
☐ Bilateral breast cancer or two breast primaries Please specify							
☐ Ashkenazi Jewish ancestry with breast or ovarian cancer							
☐ Pancreatic or Prostate Cancer Please specify							

Colorectal and Endometrial Cancer	Patient	Immediate Blood Relatives		Extended Blood Relatives (Aunts, Uncles, Grandparents, etc.)			
	Age at Diagnosis	Parents, Siblings or Children	Age at Diagnosis	Mother's Side	Age at Diagnosis	Father's Side	Age at Diagnosis
☐ Colorectal cancer or several pre-cancerous polyps (adenomas) at an age ≤ 50							
☐ An individual who has been diagnosed with two or more colon cancers (not reccurrences, but two separate primary cancers)							
☐ A female relative who has been diagnosed with endometrial cancer at age ≤ 50 OR both colorectal and endometrial cancers Please Specify							
☐ 10 or more total pre-cancerous polyps (adenomas) in a person's lifetime							
☐ Relatives with any of the below related cancers* Please Specify							

*Related cancers include colon, endometrial , ovarian, stomach, pancreas, ureter, kidney, biliary tract, brain, small intestine, and sebaceous gland tumors/cancers

Patient: ______________________________ Date: ____________________

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No

General

Have you gained or lost weight recently?	Y	N
How many pounds?	_____	
Are you concerned about your weight?	Y	N
Other		

Integumentary

Skin rash	Y	N
Nipple discharge	Y	N
Persistent itch	Y	N

Neurological

Trouble sleeping	Y	N
Headache	Y	N
Seizures	Y	N
Other		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Frequent urination	Y	N
Other		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		

Respiratory

Asthma	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Anemia	Y	N

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other		

Psychiatric

Are you unhappy with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other		

Aesthetics

Are you troubled by painful intercourse, vaginal dryness?	Y	N
Are you concerned with your appearance? (fine lines, wrinkles, sun spots)	Y	N

Physician Reviewed: ______________________________

CURRENT PRESCRIPTIONS

PT NAME	TODAYS DATE

Drug Name	Generic for	Dose	Frequency	Reason Taking

Aviso De Privacidad Reconocimiento

Andrew Krinsky, MD, LLC

Entiendo que bajo el Health Insurance Portability And Accountability Act (HIPPA), tengo ciertos derechos a la privacidad con respecto a mi información de salud protegida. Reconozco que han recibido o han tenido la oportunidad de recibir una copia de su aviso de practicas de privacidad. También entiendo que esta práctica tiene el derecho de cambiar su aviso de practicas de privacidad y que puedo contactar con la practica en cualquier momento para obtener una copia actual de la notificación de practicas de privacidad

________________________________ ________________

Nombre del paciente o la legal de guarda (impresión) Fecha

____

Firma

Uso de oficina solamente:

Hemos hecho el siguiente intento de obtener la firma del paciente reconoce el recibo de la notificación de practicas de privacidad:

Fecha: ____________ Intento:__________________________

Nobre De Empleado:______________________________

Notice Of Privacy Acknowledgement

Andrew Krinsky, MD, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice Of privacy Practices.

______________________________________ ____________________

Patient Name or Legal Guardian (PRINT) Date

Office Use Only

We have made the following attempt to obtain the patients signature acknowledging receipt of Notice of privacy practices:

Date:______________ Attempt:______________________________

Staff Name:____________________________________

Andrew Krinsky, MD, LLC
7401 N. University Dr, Suite 101, Tamarac, FL, 33321,
Telephone: (954) 722-2002 ~ Fax: (954) 722-2041

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ______________________ ID Number: ____________________

Date of Birth: ______________________

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	Persons/organizations receiving the information:
PCP-	DR. Andrew Krinsky
GYN-	GYN
Specific description of information (including dates):	**Purpose of requested use or disclosure:**
last (3) yrs of Blood work, Pap,	Medical records
CT scan, Mamo results, Doc notes, labs	

The patient or the patient's representative must read and initial the following statements:

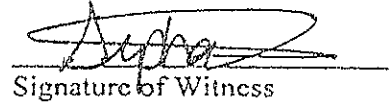
		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

______________________________ Signature of Patient or Legal Representative

______________________________ Date

______________________________ If Signed by Legal Representative, Relationship to Patient



______________________________ Signature of Witness

This document will be retained by the providing organization for six years.

CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

In an effort to relay Normal results faster to our patients we have implemented Electronic Medical Records.

I understand that in order for Andrew Krinsky, MD, LLC to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to Andrew Krinsky, MD, LLC.

I further understand that in order for Andrew Krinsky, MD, LLC to text detailed messages containing specific medical information to my cell phone I need to give my written express permission to Andrew Krinsky, MD, LLC. I also understand that my healthcare information at Andrew Krinsky, MD, LLC is protected and a copy of the Notice of Privacy Practices is available upon my request.

Consent for Messages

I give my written express consent to Andrew Krinsky, MD, LLC to leave detailed messages on my voicemail/answering machine about my NORMAL lab results, diagnostic and/or imaging results, prescription information, or appointment reminders.

No abnormal results will be communicated via our automated system.

I AUTHORIZE ANDREW KRINSKY, MD, LLC TO SEND AUTOMATIC ELECTRONIC COMMUNICATION VIA TEXT/EMAIL/VOICEMAIL MESSAGES.

Patient Name (Please Print):______________________________ **Date:**__________

Patient Signature:______________________________ **Cell #:**______________________________

(this number will be used for messaging)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that I must provide written notice in order to revoke this consent.