

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, it is your responsibility to be aware of the date and time.
- 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.
- L. **I consent to a medically indicated exam including but not limited to a pelvic exam.**

I HAVE READ AND UNDERSTAND THE ABOVE

Signed by: _____ DATE: _____

I hereby 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

NAME		AGE		OCCUPATION		S.M.D.		SEP
FAMILY HISTORY		AGE	LIVING HEALTH	AGE	DECEASED HEALTH	Has any relative ever had		WHO
						NO	YES	
FATHER								
MOTHER								
BROTHER OR SISTER		1						
		2						
		3						
		4						
		5						
HUSBAND								
SON OR DAUGHTER		1						
		2						
		3						
		4						
		5						

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	DO YOU NOW HAVE OR HAVE EVER HAD		YES	NO
GERMAN MEASLER	☐	☐	☐	ANY EYE DISEASE, INJURY, IMPAIRED SIGH	☐	☐	☐
MUMPS	☐	☐	☐	ANY EAR DISEASE, INJURY, IMPAIRED HEAF	☐	☐	☐
CHICKEN POX	☐	☐	☐	ANY TROUBLE WITH NOSE, SINUSES, MOUT	☐	☐	☐
SCARLET FEVER	☐	☐	☐	ANY HEAD INJURY, FAINTING SPELLS, CON	☐	☐	☐
DIPHTHERIA	☐	☐	☐	FREQUENT OR SEVERE HEADACHES	☐	☐	☐
PNEUMONIA	☐	☐	☐	SKIN DISEASE	☐	☐	☐
RHEUMATIC FEVER	☐	☐	☐	CHRONIC OR FREQUENT COUGH	☐	☐	☐
HEART DISEASE	☐	☐	☐	CHEST PAIN, SPITTING UP BLOOD	☐	☐	☐
HEART MURMUR	☐	☐	☐	NIGHT SWEATS	☐	☐	☐
POLIO OR MENINGITIS	☐	☐	☐	SHORTNESS OF BREATH	☐	☐	☐
KIDNEY INFECTIONS	☐	☐	☐	SWELLING OF HANDS, FEET, OR ANKLES	☐	☐	☐
GONORRHEA OR SYPHILIS	☐	☐	☐	VARICOSE VEINS	☐	☐	☐
ANEMIA	☐	☐	☐	KIDNEY OR BLADDER DISEASE	☐	☐	☐
JUANDICE	☐	☐	☐	INDIGESTION, STOMACH TROUBLE, OR ULC	☐	☐	☐
GALLBLADDER DISEASE	☐	☐	☐	RECTAL BLEEDING, CONSTIPATION OR DIA	☐	☐	☐
EPILEPSY	☐	☐	☐	LOSS OF URINE WITH COUGH OR SNEEZE	☐	☐	☐
MIRRAINE HEADACHES	☐	☐	☐	ALCOHOLIC BEVERAGE ☐ NEVER ☐ MOD ☐ DAILY	☐	☐	☐
TUBERCULOSIS	☐	☐	☐	CIGARETTES _____ PACKS PER DAY	☐	☐	☐
VALLEY FEVER	☐	☐	☐	SURGERY - (IF YES, WHAT, WHEN, WHERE)	☐	☐	☐
CANCER	☐	☐	☐		☐	☐	☐
HIGH OR LOW BLOOD PRESSURE	☐	☐	☐		☐	☐	☐
NERVOUS BREAKDOWN	☐	☐	☐		☐	☐	☐
				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
<u>Example:</u> Female relative with Breast Cancer at age $\leq$ 50	45	Mother Sister	49 36	Maternal Aunt	46	Paternal First Cousin	50
☐ Female relative with Breast Cancer at age $\leq$ 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 $\leq$ 50							
☐ An individual who has been diagnosed with two or more colon cancers (not recurrences, but two separate primary cancers)							
☐ A female relative who has been diagnosed with endometrial cancer at age $\leq$ 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? Y N

(fine lines, wrinkles, sun spots) Y N

Physician Reviewed: _____

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[illegible]

Notice of Privacy Acknowledgement

Andrew Krinsky, MD, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), 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

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

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 GYN	DR. Andrew Krinsky GYN
Specific description of information (including dates):	Purpose of requested use or disclosure:
last (3) yrs of Blood work, Pap, CT scan, Mamm results, Doc notes, labs	Medical Records "

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

		Initials
1.	I understand that this authorization will expire on <u> </u> / <u> </u> / <u> </u> (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

Alpha
Signature of Witness

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