ADULT MEDICAL SERVICES PC
6645 Main St. Suite A, Williamsville, NY 14221
(716) 276-8726 (Office)
(716) 276-8730 (Fax)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date:_____

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PRIMARY INSURANCE

Person responsible for Account _____
Last Name First Name Middle Initial

Relation to patient_____DOB_____SSN_____

Address (if different from patient's)_____Phone_____

City_____State_____Zip_____

Insurance Company_____

ID Number_____Group Number_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? YES NO

Person responsible for account_____
Last Name First Name Middle Initial

Address (if different from patient's)_____Phone_____

City_____State_____Zip_____

Insurance Company_____

ID Number_____Group Number_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
And assign directly to Dr. _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed, or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative **Date**

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

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PATIENT INFORMATION

Name _____
Last Name First Name Middle Initial

DOB_____Sex: M F SSN:_____

Home Address: _____

Phone: Home:_____ Cell_____

Person to be notified in Emergency:

Name/Relationship: _____

Home Phone_____ Business Phone_____ Cell Phone_____

Previous Physician_____Phone_____

Address_____Date of Last Visit_____

Your Employer_____

Address_____

Spouse's Employer_____

Address_____

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PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient _____
Last Name First Name Middle Initial

Address_____

Date of Birth _____

ADULT MEDICAL SERVICE is authorized to furnish to/receive from (circle desired choice):
Recipient/Discloser: _____

For the Purpose of: _____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

☐ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records r copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMSATION which may include information concerning mu treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapists, psychologists, if any.

☐ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

_____

_____

I release Adult Medical Services, Inc, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Adult Medical Services, PC, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on __/__/__(Optional). If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.

_____ _____
Patient Signature (Parent's Representative if minor) **Date**

_____ _____
Witness Signature **Date**

So that we may improve our patient care, please let us know the reason you are requesting this record release (check all that apply):

☐ **Not satisfied with Provider (which provider?)_____**

☐ **Not satisfied with Staff (which staff member?)_____**

☐ **Moving out of the area_____**

☐ **Other (please describe)_____**

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Sameer Mamnoon, MD **Hassan Fares, NP**

INSURANCE WAIVER

I, _____ state my health insurance is _____.

Should my insurance not cover my office visit, I agree to pay the bill for this visit in full.

_____

Name

_____

Witness

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_____

Name DOB Date

Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all six pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank You!

Main reason for today's visit: _____
Other concerns: _____
What are your health goals for the next year?:_____
Where were you getting your care before?:_____

Review of symptoms: Please mark the box and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you.

General
__Unexplained weight loss/gain
__Unexplained fatigue/weakness
__ Fall asleep during the day when sitting
__Fever, chills
__ No problems

Skin
__ New or change in mole
__ Rash/itching
__ No problems

Breast
__ Breast lump/pain/nipple discharge
__ No problems

Ears/Nose/Throat
__ Nosebleeds,trouble swallowing
__ Frequent sore throat,hoarseness
__ Hearing loss/ringing in ears
__ No problems

Eyes
__ Change in vision/eye pain/

Cardiovascular
__ Chest pain/discomfort
__ Palpitations (fast or irregular heartbeat)
__ No problems

Respiratory
__ Cough/wheeze
__ Loud snoring/altered breathing during sleep
__ Short of breath with exertion
__ No problems

Gastrointestinal
__ Heartburn/reflux/indigestion
__ Blood or change in bowel movement
__ Constipation
__ No problems

Genitourinary
__ Leaking urine
__ Blood in urine
__ Nighttime urination or increased frequency
__ Discharged: penis or vagina
__ Concern with sexual frustration
__ No problems

Musculoskeletal
__ Neck pain
__ Back pain
__Muscle/joint pain
__ No problems

Endocrine
__ Heat or cold sensitivity
__ No problems

Hematologic/Lymphatic
__ Swollen glands
__ Easy bruising
__ No problems

Neurological
__ Headache
__ Memory loss
__ Fainting
__ Dizziness
__ Numbness/tingling
__ Unsteady gait
__ Frequent falls
__ No problems

Allergic/Immune
__ Hay fever/allergies
__ Frequent infections
__ No problems

Psychiatric
__ Anxiety/stress/irritability
__ Sleep problem
__ Lack of concentration
__ No problems

Women Only
__ Pre-menstrual symptoms (bloating,cramps,irritability)
__ Problem with menstral periods
__ Hot flashes/night sweats
__ No problems

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known.

Tetanus(Td)_____ With Pertussis(Tdap)_____ Varicella(Chicken Pox) shot or illness_____ Pneumovax(pneumonia)_____ Influenza(flu shot)_____ Hepatitis A_____ Hepatitis B_____ MMR_____ Meningitis_____ Zostavax(shingles)_____ HPV_____

MEDICATIONS: Please list (or attach your own printed record) of all prescription and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

□ **TAKE NO MEDICATIONS**

Medication Dose(e.g mg/pill) How many times per day?

_____

_____

_____

_____

_____

_____

Allergies or intolerance to medications (include type of reaction):_____

_____□**NONE**

HEALTH MAINTENANCE SCREENING TESTS:

Lipid(cholesterol)	Date_____	Abnormal?	□ No	□ Yes
Sigmoidoscopy:	Date_____	Abnormal?	□ No	□ Yes
Colonoscopy:	Date_____	Abnormal?	□ No	□ Yes
Women only:				
Mammogram	Date_____	Abnormal?	□ No	□ Yes
Pap Smear	Date_____	Abnormal?	□ No	□ Yes
Bone Density Test	Date_____	Abnormal?	□ No	□ Yes

SOCIAL HISTORY

Occupation(or prior occupation):_____retired/unemployed/leave of absence/disabled (circle one)
Employer:_____Years of education or highest degree:_____
Marital Status(circle one): Single/Partner/Married/Divorced/Widowed/Other:_____
Spouse/Partner's Name:_____Number of Children____Ages if under 18_____
Number of Grandchildren:_____ Number of Great Granchildren:_____
Who Lives at Home with You?:_____
Leisure activities, group involvement, religion, volunteer work, recent travel:_____
_____
_____

WOMEN'S HEALTH HISTORY

Total number of pregnancies:_____ Number of births:_____
Date(Month/Day if known) of last menstrual period(if still menstruating):_____
Age you started menstruating:_____ Age you stopped menstruating(menopause):_____

OTHER HEALTH ISSUES

Tobacco Use:
Smoke Cigarettes: □ Yes □ Quit □ Never
Quit Date:_____
How many years did you smoke?_____
Approx. how many packs a day did you smoke?_____
Current Smoker: Packs/Day:____ # of years:_____
Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use:
Do you drink alcohol? □ Yes □ No
# of Drinks/Week:_____ □ Beer □ Wine □ Liquor

Drug Use:

Do you use marijuana or recreational drugs? □ Yes □ No
Have you ever used needles to inject drugs? □ Yes □ No

Sexual Activity:

Sexually Active? □ Yes □ No
Sexual partner(s) is/are/have been: □ Male □ Female
Birth Control Method(circle below all that apply):
Condom, Pill, Diaphragm, Vasectomy, Other:_____
□ None Needed

Exercise:
Do you exercise regularly? □ Yes □ No
What kind of exercise?
_____
_____
_____
_____
How long(minutes)?_____
How often?_____

Diet:
How would you rate your diet? □ Good □ Fair □ Poor
Would you like advice on your diet? □ Yes □ No

Saftey:
Do you use a bike helmet? □ No Bike □ Yes □ No
Do you use seatbelts consistently? □ Yes □ No
Does your home have a working smoke detector? □ Yes □ No

If you have guns in your home, are they locked up properly? □ Not Applicable □ Yes □ No
Is violence at home a concern for you? □ Yes □ No

Have you completed an Advance Directive for Health Care(ADHC), Living Will, or POLST(Physician Orders for Life Sustaining Therapy)? (Circle all that apply) □ No

PERSONAL MEDICAL HISTORY: Do you have now or have you had any of the following conditions? □ **NONE**

CONDITION	CURRENT	PAST	COMMENTS
Alcohol/Drug Abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Blood-Clot (Leg)			
Blood-Clot (Lung)			
Blood Transfusion			
Breast Lump (Benign)			

Cancer Breast			
PERSONAL MEDICAL HISTORY CONT. **Condition**	**Current**	**Past**	**Comments**
Cancer Colon			
Cancer Ovarian			
Cancer Prostate			
Cancer (Other Type)			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (Adult Onset)			
Diabetes (Childhood Onset)			
Diverticulosis			
Emphysema			
Fractures (Broken Bones)			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions			
Heart Attack			
Hepatitis – Type A			
Hepatitis- Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholestrerol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (Enlargement)			
Prostate (Nodules)			
Seizure/Epilepsy			
Skin Condition			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive)/Hyperthyroidism			
Thyroid Low (Underactive) Hypothyroidism			
Other (List)			

SURGICAL HISTORY – Please check off any procedure or surgeries. List any abnormal findings or complications □ **NONE**

Surgical Procedure	Yes	Year	Comments
Abdominal Surgery			
Appendectomy (Appendix Removal)			
Back Surgery (Lumbar)			
Biopsy (Location)			
Breast Biopsy			Circle: Right Left Both
Breast Surgery			Circle: Right Left Both
Colonoscopy			
Coronary Bypass			
Coronary Stent			
EGD (Stomach Endoscopy)			
Cataract			
Gallbladder Removal			Circle: Laparoscopic
Heart Surgery (Other than Coronary Bypass)			
Hip Surgery			Circle: Right Left Both
Hysterectomy (Total Including Ovaries)			Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (Partial, Ovaries Left)			Circle: Laparoscopic Vaginal Abdominal
Knee Surgery			Circle: Right Left Both
LEEP (Cervix Surgery)			
Neck Surgery			
Ovary Ligation (“Tubal”)			
Ovary Removal			Circle: Right Left Both
Vasectomy			
Sigmoidscopy			
Sinus Surgery			
Other (List)			

Adopted – □ Yes □ No (please circle) If yes and you do not know your family history skip this section.

FAMILY HISTORY-Indicate which relative has had the following diseases (parents and siblings are most important)

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No Significant History										
Alcoholism/Drug Abuse										
Alzheimers										
Asthma										
Autouimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Ovarian										
Cancer Prostate										
Cancer (Other Type)										
Colon Polyp										
Coronary Artery Disease										
Depression/Suicide/Anxiety										
Diabetes (Adult Onset)										
Diabetes (Childhood Onset)										
Emphysema (COPD)										
Genetic Disorder (Explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure										
High Cholesterol										
Hip Fracture										
Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (List)										