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):**_____

POLICY NUMBER:_____ **GROUP NUMBER:**_____

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	Financial Policies
Referrals to Other Providers	Office Policies
Credit Card Policy	Vaccine Policy
Physician Participation and Affiliation Information	Documentation Preparation Fees

Language Spoken	○ English ○ Spanish ○ Korean ○ Other Language: _____	**Ethnicity:**	○ Decline to State ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown
Race:	○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Native Hawaiian or Other Pacific Islander ○ White ○ Other Race: _____	**Marital Status:**	○ Single ○ Married ○ Other: _____
		Student Status	○ Not a Student ○ Full Time ○ Part Time
Sexual Orientation:	○ Lesbian, gay or homosexual ○ Straight or heterosexual ○ Bisexual ○ Something else, please describe ○ Do Not Know ○ Choose Not to Disclose	**Gender Identity**	○ Identifies as Male ○ Identifies as Female ○ Female to Male ○ Male to Female ○ Genderqueer ○ Additional Gender ○ Choose Not to Disclose
Gender:	○ Male ○ Female ○ Other: _____		

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.

Sharing Health Information with Family Members and Friends: The following is a list of the names those who I wish to receive my medical information (which includes test results):_____

_____

_____

Please note the following:

- **Only those listed on the line above may call the office and speak with our staff regarding your health;**
- **Include your SPOUSE or PARENT, if you are over 18 years old, if you want our staff to speak with them; and**
- **This form overrides any previous HIPAAs completed.**

_____ _____

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: _____ Exp:_____

Please indicate if this is an HAS/FSA Card ____ or Credit Card ____.

Our office does not take Debit cards.

Please Note: We offer both a cash and credit card price. To see our pricing schedule, visit: https://www.drscafuri.com/club/scripts/library/view_document.asp?NS=MS&DN=VaccineandCopay.

PLEASE LIST THE SPECIALISTS YOU ARE SEEING:

Allergies/ENT		Orthopedist	
Cardiologist		Pain Management	
Chiropractor		Podiatrist	
Dermatologist		Psychiatrist	
Endocrinologist		Pulmonologist	
Nephrologist		Rheumatologist	
Neurologist		Surgeon	
OB/GYN		Urologist	
Oncologist/Hematologist		Vascular	
Ophthalmologist		Other	

I AUTHORIZE THE RELEASE OF HEALTH INFORMATION TO DR. SCAFURI & ASSOCIATES FROM ANY SPECIALISTS LISTED ABOVE.

_____ _____

PATIENT'S SIGNATURE **DATE**