ANTHONY L. CUPPARI, MD, FACS

Initial Date of Service _____

PATIENT INFORMATION			
Patient Name:			Gender: M F
Birthdate:	Social Security #:		Marital Status: S W D M
Mailing Address:			Apt#:
City:	State:		Zip Code:
Home Phone:	Cell Phone:		
E-Mail Address:			
Reason for this Visit:			
Referring Physician's Name, Address & Phone Number:			
Height: FT. IN.	Weight: LBS.		

VERY IMPORTANT: US Government Healthcare laws require the following information:

Patient's Race (Mandatory, Please CHECK your selection):	Asian	Black	Hispanic	White
Patient's Primary Language (Mandatory, Please CHECK your selection):	English	Spanish	Other	
Patient's Ethnicity (Mandatory, Please CHECK your selection):	1 - Latino	2 - Non-Latino		

EMPLOYER INFORMATION	
Employer/School Name:	Their Phone:

INSURANCE POLICY INFORMATION		
Primary Insurance:	Subscriber Name:	
Relation To Patient:	Subscriber Birthdate:	Subscriber ID#:
Secondary Insurance:	Subscriber Name:	
Relation to Patient:	Subscriber Birthdate:	Subscriber ID#:

EMERGENCY CONTACT	
Name:	Relation To Patient:
Home Phone:	Cell Phone:

INSURANCE AUTHORIZATION AND FINANCIAL RESPONSIBILITY

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM(S). I AUTHORIZE AND DIRECT MY INSURANCE CARRIER OR IT'S INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY TO ANTHONY L. CUPPARI, MD FOR SERVICE(S) RENDERED.

I UNDERSTAND THAT MY INSURANCE CARRIER MAY REQUIRE AN AUTHORIZATION NUMBER, PRECERTIFICATION AND/OR REFERRAL. WITHOUT THIS DOCUMENTATION, I UNDERSTAND THAT MY INSURANCE CARRIER MAY DENY BENEFITS. IF MY INSURANCE CARRIER DENIES PAYMENT FOR SERVICES RENDERED BY ANTHONY L. CUPPARI, MD, I AGREE TO BE RESPONSIBLE FOR PAYMENT.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. FURTHER, I UNDERSTAND THAT YOUR OFFICE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTION OF MY CLAIM OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT WITHIN THE LIMITS OF YOUR CREDIT POLICY. IF I FAIL TO PAY MY PORTION OF AMOUNTS NOT COVERED BY INSURANCE IN A TIMELY MANNER, I AGREE TO PAY THE COSTS OF COLLECTING THE AMOUNT THAT I OWE INCLUDING INTEREST, PENALTIES AND APPLICABLE COURT COSTS.

SIGNED: _____ DATE: _____

SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: ..... **Date of Birth**: ..../..../.....
FIRST LAST

Patient's Height: ..... feet ..... inches **Weight:** ..... pounds **Gender:** Male Female

Complete if you see a **Primary Care MD:** .....

Complete if you see a **Specialist MD:** .....

Circle type of Specialist MD: Cardiologist Endocrinologist GI Other

PATIENT's MEDICAL HISTORY (Check where applicable):

- Appendicitis
- Arthritis
- Asthma
- Bleeding (Other Disorders)
- Blood in Bowel Movement
- Blood in Urine
- Cancer
- Cataracts
- Cramps, Severe or Frequent
- Crohn's Disease
- Diabetes
- Diverticulitis
- Ear Diseases
- Gallstones
- Heart Attack
- Heart Disease
- Heart Rhythm Issue(s)
- Hepatitis
- Hernia
- High Blood Pressure
- High Cholesterol
- HIV / AIDs
- Immunity problems
- Kidney Disease
- Kidney Stones
- Liver Disease
- Lung Disease
- Mental Illness
- Musculoskeletal Disease
- Neurological Disease
- Non-Healing Wound(s)
- Pain, Abdominal
- Pain, Back
- Pain, Chest
- Pain, Other
- Pancreatitis
- Seizures (Epilepsy)
- Skin Problems
- Stomach Ulcers
- Stroke
- Thyroid Disease
- Urinary Tract Infection
- Vaginal Infections
- OTHER (List on line below):

.....

SURGICAL HISTORY (List all Operations & Dates - Month / Year):

.....

.....

ALLERGIES (if you brought a list just check here):

.....

.....

MEDICATIONS (if you brought a list just check here):

.....

.....

.....

SOCIAL HISTORY (Circle your choice / complete where asked):

Have you ever smoked? Y N

Do you smoke now? Y N

How many per day/week? ..../.....

Marital Status:
Single Married Widowed

Do you drink alcohol? Y N

How many per day/week? ..../.....

Do you now use any recreational drugs? Y N

Have you served in the military? Y N

Have you ever lived in another country? Y N

Where? .....

How long ago? .....

EMPLOYER NAME: .....

FAMILY HISTORY (Any Blood Relative(s) who have or had - Check & List: **S** = Siblings, **P** = Parents, or **G** = Grandparents):

- Brain Cancer
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Lung Cancer
- Mouth/Throat Cancer
- Ovarian Cancer
- Penile Cancer
- Prostate Cancer
- Testicular Cancer
- Uterine Cancer
- Alcohol/Drug Abuse
- Diabetes
- Gastrointestinal Disease
- Heart Attack
- Heart Rhythm Problems
- High Blood Pressure
- Kidney Disease
- Liver Disease
- Mental Illness
- Neurological Disease
- Stroke

(Optional) If you checked any above condition, you can describe more here if you want to:

.....

This form was completed by (Circle choice): The Patient Relative / Friend Other

(**If NOT the Patient**, Print Name & Relationship): .....

Today's Date: ..../..../.....

Notice of Privacy Practices

followed by Anthony L. Cuppari, MD, FACS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- o Get a copy of your paper or electronic medical record
- o Correct your paper or electronic medical record
- o Request confidential communication
- o Ask us to limit the information we share
- o Get a list of those with whom we've shared your information
- o Get a copy of this privacy notice
- o Choose someone to act for you
- o File a complaint if you believe your privacy rights have been violated
- o Pay no more than $1.00 per page or $100.00 for the whole records whichever is less

Your Choices

You have some choices in the way that we use and share information as we:

- o Tell other people about your condition which is limited to healthcare professionals
- o Provide disaster relief following local & national emergencies
- o Include you in a hospital directory - only if you agree to our written request to do so
- o Provide mental health care
- o Market our services - we never sell or provide your information. If you volunteer a testimonial letter, we must first ask you before making it public.
- o Raise funds to run our organization

Our Uses and Disclosures

We may use and share your information as we:

- o Treat you
- o Run our organization
- o Bill for your services
- o Help with public health and safety issues
- o Do research
- o Comply with the law
- o Respond to organ and tissue donation requests
- o Work with a medical examiner or funeral director
- o Address workers' compensation, law enforcement, and other government requests
- o Respond to lawsuits and legal actions

This notice is a summary of the entire HIPAA Privacy Practice Law that we follow. If you would like a complete, detailed version of the law as it applys to your privacy with our practice, please let us know and we will provide you with a copy free of charge.

I have received a summary copy of Anthony L. Cuppari, MD's Privacy Policy summary and may at any time request a complete version for my records.

SIGNED: ..... DATE: .....

Name Printed: .....