Welcome to Empire OBGYN. An appointment has been scheduled for you at our office on:

DATE:	TIME:
DR.:	LOCATION: 3834 DELAWARE KENMORE 14217

We hope that the following information will be helpful to you. We appreciate your time and would like to make your visit to our office as efficient as possible.

Parking: is available in our parking lot in front of our building. Please arrive 15 minutes prior to your scheduled appointment time in order to complete the registration process.

Prior to your appointment: Please complete the enclosed New Patient Packet and mail it **back AT LEAST 1 week before your appointment.** Please use the envelope provided. You can also set up your patient portal with the letter provided and upload these forms through the portal. Failing to return your New Patient Packet ahead of time may result in your appointment needing to be rescheduled for a later date. You may also fax your New Patient Packet to 716-218-2721.

On your appointment Day: Please bring a list of your current medications (prescription and over the counter). If we sent you a records release form, please forward this form to your previous Physician so we may obtain your records for your visit.

Medical Insurance: Please bring your insurance card with you to your appointment. We need the actual card or a printed copy of the card. We cannot accept a digital card on your cell phone. Your insurance reimbursement may not cover the full cost of your medical services we provide you. Regardless of insurance, payment remains your responsibility.

Financial Responsibility: Your co-payment is collected at the time services are rendered. This office accepts checks or bank cards. If you have a high deductible plan, please be prepared to pay for the cost of your visit unless it is an Annual Exam. If you have questions, please contact the Billing Office directly at 716-206-0692. **PLEASE NOTE THERE IS A $30 NO SHOW FEE FOR ANY APPOINTMENT MADE THAT IS NOT CANCELED 48 HOURS PRIOR. PLEASE BE SURE TO CALL THE OFFICE IF YOU CANNOT KEEP THE ABOVE SCHEDULED APPOINTMENT TO AVOID BEING CHARGED.**

If you have any further questions regarding the above information, please contact our office at

(716) 877-1221 or (716) 684-5454. You may also visit our website at www.empireobgyn.com.

Thank you and we look forward to seeing you at your first visit with us.

Sincerely,

Dr. Rachel Weselak, Helen Murphy WHNP, Kristen Kloosterman WHNP, Terrie Palazzo, PA

3834 Delaware Ave, Kenmore, NY 14217
(716)877-1221

Please take a few minutes to answer the following questions so we may better assist you with your health care needs

PATIENT INFORMATION

Name (First)______________________________(MI)______Last______________________ Date_____________

Address____City________________________Zip Code___________

Birthdate_____________ Phone______________ Cell Phone ____________ Social Security_________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor Child

Employer____ Phone ___________________

Address ___________________________________ Occupation ______________________________

City/State/Zip_____________________________ Referred by ______________________________

In an Emergency, whom should we contact: 1. ____________________________ Phone ____________

Pharmacy Phone Number ____________________ 2. ____________________________ Phone ____________

Email Address ____

SPOUSE/RESPONSIBLE PERSON INFORMATION

Name (First) ________________________________(M)___________________Last_________________________

Address (if different from patient)________________________City/State/Zip______________________________

Social Security Number ________________________ Birthdate________________ Phone___________________

Employer ______________________________ Address____

Occupation___________________________ City/State/Zip______________________________Phone__________

INSURANCE INFORMATION

Primary Insurance ___________________________ Subscriber_____________________________________

ID No. _____________________________ Group No. ______________________ Effective Date ____________

Secondary Insurance __________________________ Subscriber ____________________________________

ID No. ________________________________ Group No. _____________________ Effective Date ____________

Race: White_____ Black/African American_____ American Indian/Alaska Native_____
Native Hawaiian/Other Pacific Islander _____ All other races _____ Decline to specify/Unknown ______

Ethnicity: Hispanic/Latino_______ Not Hispanic/Latino_______ Declined to specify/Unknown______

NAME______________________________DOB____/_____/______TODAYS DATE____/____/_____

Current Primary Care Physician ____

Do you have any allergies to medications or other substances? Yes _____ No _____

If yes, please list allergies and reactions (rash, hives, throat swelling, anaphylaxis)

____

____

____

Please list ALL of your current medications below (use back of page if you need more room)

MEDICATION NAME	DOSAGE	WHEN DO YOU TAKE IT

Please list all current medical problems/diagnosis____

____

____

Please list all previous surgeries ____

____

____

(OVER)

First day of last menstrual period: ____________ Age of first menstrual period: _______________

Have you ever been sexual active?____________ Currently:_________ Past:_________

Total number of pregnancies _______

Live births _________ Vaginal Deliveries _________ Cesarean Sections _______

Miscarriages ________ Tubal Pregnancies ________ Terminations _________

Living Children _____

When was your last Routine GYN Exam? ______________

When was your last PAP Smear? _________________

Have you ever had an abnormal PAP? Yes ____ No ____

If yes, When? ____________

Date of last Mammogram ____________ Normal _____ Abnormal ______ N/A ______

Date of last Bone Density (DEXA) ____________ Normal _____ Abnormal _____ N/A_____

Date of last Colonoscopy _____________ Normal _____ Abnormal _____ N/A_______

Family history of Breast Cancer? Yes________ No________

If yes, who: ____

Family history of Colon Cancer? Yes_________ No________

If yes, who: ____

Family history of Ovarian Cancer? Yes_________ No _________

If yes, who: ____

Family history of Uterine Cancer? Yes_________ No________

If yes, who:____

Marital Status: Single_____ Married_____ Widowed_____ Divorced_____

Occupation: ______________________________

Do you use any of the following: Tobacco______ Alcohol______ Illegal Drugs___

Are you experiencing emotional or physical abuse: No_____ Yes_____(Current_____ or Past_____)

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number N/A
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) ________________ to (insert date) ________________
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: ______________________________

____

Include: (*Indicate by Initialing*)

________ **Alcohol/Drug Treatment**

________ **Mental Health Information**

________ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here __________ I authorize ______________________________

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

______________________________ Date: ______________________

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**