

PATIENT REGISTRATION FORM

First Name _____ Middle _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Phone: Home(____) _____ Mobile (____) _____

Work(____) _____ Preferred Contact Number: H M W

E-Mail Address _____ Date of Birth _____

Social Security _____ Sex: M F Marital Status: S M D SO W

Race _____ Ethnicity _____ Preferred Language _____

Emergency Contact _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

INSURANCE INFORMATION

Primary Insurance _____

Secondary Insurance _____

Consent to Treatment

I consent to be evaluated and treated by Marcy Galinsky, M.D. or Susan Yahia, D.O. I fully understand that I am directly responsible for all medical bills submitted for services rendered to me. I further understand that such payment is not contingent on any settlement or insurance payment.

Date _____ Signature _____

MARCY GALINSKY, M.D., P.A.
Diplomate, American Board of Family Practice

MEDICAL PATIENT INFORMATION

Social Security _____ Date _____

Name _____ Date of Birth _____ Age _____

Occupation _____ Birth Place _____ Religion _____ S M D W Significant other _____

How did you choose us for your care? _____

Reason for today's visit _____

Serious or chronic illnesses you have had or have:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Past operations, injuries, hospitalizations:

- | |
|----------|
| 1. _____ |
| 2. _____ |
| 3. _____ |

Medications and over-the-counter drugs currently or regularly used:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Additional:

Health care providers (name & specialty) seen in the past 2 years:

| | |
|-------|--------------|
| _____ | Reason _____ |
| _____ | Reason _____ |
| _____ | Reason _____ |

PERSONAL CONCERNS

HAVE YOU RECENTLY NOTED:

YES NO

- Severe headaches
- Fainting
- Dizziness
- Weakness or Numbness of arm or leg
- Ringing in ears
- Double vision
- Tightness in chest
- Shortness of breath
- Swelling

YES NO

- Problems with sexual activity
- Problems urinating
- Pain in legs walking
- Joint pain
- Sleep problems
- Weight change
- Hoarseness
- Hernia

YES NO

- Nausea/vomiting
- Change in appetite
- Pain in abdomen
- Change bowel habits
- Blood in stool
- Change in mole
- Skin problems
- Other _____

TO BE ANSWERED BY FEMALES ONLY:

- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| Do you have regular monthly menstrual periods? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any problems with your periods? | <input type="checkbox"/> | <input type="checkbox"/> |
| Your last menstrual period _____ | | |
| Any possibility of being pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had problems with a pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use contraception? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a discharge from a nipple? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had lumps in your breast? | <input type="checkbox"/> | <input type="checkbox"/> |

TO BE ANSWERED BY MALES ONLY:

- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| Have you ever had problems with your genitals. (private parts)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a discharge from penis? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a hernia (rupture)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had prostate trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use contraception? | <input type="checkbox"/> | <input type="checkbox"/> |
| Any history of sexually transmitted disease | <input type="checkbox"/> | <input type="checkbox"/> |

FAMILY HISTORY

| | IF LIVING | | IF DECEASED | |
|-----------------------------|-----------|-----------------|--------------|-------|
| | Age | Health Problems | Age at Death | Cause |
| Father | | | | |
| Mother | | | | |
| Brothers or Sisters | | | | |
| | | | | |
| | | | | |
| Spouse or Significant Other | | | | |
| Sons or Daughters | | | | |
| | | | | |
| | | | | |

HAS ANY BLOOD RELATIVE HAD:

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes | No | Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IMMUNIZATIONS (Date)

Tetanus _____ Measles _____ Flu _____ Pneumovax _____
 Hepatitis B _____ Mumps _____ Varicella (Chicken Pox) _____
 Hepatitis A _____ Rubella _____ Polio _____

SCREENING TESTS (Most recent date and results)

| Date | Result | Date | Result |
|-------------------------|-----------|--------------------------------|--------|
| Mammogram _____ | _____ | Colorectal Cancer Screen _____ | _____ |
| Pap Smear _____ | _____ | Prostate Exam _____ | _____ |
| Cholesterol Level _____ | _____ | EKG or Stress Test _____ | _____ |
| TB Skin Test _____ | _____ | Chest X-Ray _____ | _____ |
| Dental Exam _____ | Dr. _____ | Bone Density _____ | _____ |
| Eye Exam _____ | Dr. _____ | | |

DIET: (I am) (am not) satisfied with my weight

EXERCISE: I do _____ (Activity) _____ times per Week / Month

SOCIAL HABITS: Smoking: I smoke / smoked _____ cigarettes / day for _____ years. I quit smoking in _____

Other tobacco products: _____

Alcohol: I drink _____ glasses / cans / shots or _____ per day / week / month.

Drug use: I do / do not use recreational drugs.

HOBBIES: _____

PETS IN MY HOME _____

I FEEL SAFE IN MY HOME: YES or NO

LIVING WILL: I know what an advance directive is. Yes No I have one. YES No

MARCY GALINSKY, M.D., P.A.
Diplomate, American Board of Family Practice
8700 N Kendall Drive Suite 105
Miami, Florida 33176
Phone: (305) 271-3373 Fax: (305) 271-8618

MEDICAL MALPRACTICE INSURANCE ACKNOWLEDGMENT

Dear Patient:

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR, DR. MARCY GALINSKY HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

I, _____, have read and understand the above.
Patient's Name (Print)

Patient's Signature

Date

If minor, Parent's/Guardian's Signature

PATIENT CONSENT FORM

Use of this form is optional and not required under the HIPAA privacy rule.

Marcy Galinsky, M.D.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Marcy Galinsky, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Marcy Galinsky, M.D. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Marcy Galinsky M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Marcy Galinsky, M.D. at 8700 N Kendall Drive, Miami, Florida 33176.

With this consent, Marcy Galinsky, M.D. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Marcy Galinsky, M.D. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Marcy Galinsky, M.D. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Marcy Galinsky M.D. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Marcy Galinsky, M.D. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Marcy Galinsky, M.D. may decline to provide treatment to me.

Signed by: _____
Signature of Patient or Legal Guardian Date Relationship to Patient

Print Patient's Name Print Name of Legal Guardian, if applicable



Marcy Galinsky, M.D., P.A.

Diplomate, American Board of Family Practice

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galinsky@bellsouth.net

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____ DATE: _____

FAX/ADDRESS: _____

NAME OF PATIENT: _____ DOB: _____

ITEMS REQUESTED: _____

Please release my medical records and information regarding my treatment, hospitalization, and/or outpatient care for my condition, including, but not limited to, psychological or psychiatric impairment, drug abuse, and or alcoholism, sickle cell anemia, AIDS (Acquired Immune Deficiency Syndrome), AIDS-related complex (ARC) and HIV antibody testing to:

MARCY GALINSKY, M.D.
8700 N KENDALL DR. SUITE 105
MIAMI, FL 33176
(305)271-3373 phone
(305)271-8618 fax
GALINSKY@BELLSOUTH.NET

Signature _____ DATE: _____