Cherese M LaPorta D.O., PLLC
107 North Ocean Ave
Suite G
Patchogue, NY 11772
(631)654-5004

PATIENT REGISTRATION (please print)

1. Patient's Full Name ______________________________
2. Sex: (Please circle one) Male, Female or Other
3. Race: (Please circle one) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian, Other, Patient Declined
   Ethnicity: (Please circle one) Non-Hispanic, Hispanic, Patient Declined
4. Patient's Social Security # ______________________________
5. Date of Birth ____________________ Age __________
6. Patient's Home Address
   ____
   Patient's Email Address ______________________________
7. Financial Responsibility: Patient or Other (Please circle one)
8. Referring Doctor ______________________________
9. Patient's Home Phone (___) ______________
   Patient's Cell Phone (___) ______________
   Patient's Work Phone (___) ______________
10. Is the Patient Currently Employed? Yes or No (Please circle one)
    Patient's Employer ______________________________
    Employer's Address ______________________________
11. Patient's Marital Status S/M/D/W/SEP (Please circle one)
    Spouse's Name ____________________
12. Person we may contact in case of an emergency:
    Relationship ____________________
    Name ____________________
    Phone # ____________________
    Address ____________________

INSURANCE INFORMATION – **We cannot file your insurance without complete information and a copy of your insurance card(s). Please bring your insurance card with you to the front desk when you have completed this form.**

PRIMARY INSURANCE COVERAGE

13. Insurance Company: ____________________
    Address: ____________________
14. Subscriber's Name: ____________________
15. Patient's Relationship to Subscriber : Self, Spouse, Partner, Child, Other (Please circle one)
16. Subscriber's Date of Birth: ______________
17. Subscriber's Social Security # ______________
18. Subscriber's Employer: ______________
19. Subscriber's ID #: ______________
20. Group #: ______________

SECONDARY INSURANCE COVERAGE

21. Insurance Company: ______________________________
    Address: ______________________________
22. Subscriber's Name: ______________________________
23. Patient's Relationship to Subscriber: Self, Spouse, Partner, Child, Other (Please circle one)
24. Subscriber's Date of Birth: ______________________________
25. Subscriber's Employer: ______________________________
26. Subscriber's ID#: ______________________________
27. Group #: ______________________________

OTHER INSURANCE Yes or No (Please circle one)

FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATEMENT: I hereby authorize Cherese M. LaPorta D.O., PLLC and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient states above ("Patient") such medical care, examination and treatment as may be ordered by a physician in his or her medical judgement and such medical care, examination or treatment as is reasonable incident thereto. I hereby authorize direct payment to Cherese M. LaPorta D.O., PLLC of all medical insurance benefits (including without limitation Medicare benefits) to which the patient is entitled in consideration to services to be rendered by Cherese M. LaPorta D.O., PLLC to the patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to Cherese M. LaPorta, D.O., PLLC on demand for all such charges.

I hereby understand and agree that I will be charged a $25.00 fee for any appointments that I do not cancel with 24 hours.

Signature: ______________________________ **Date:** ________________

(Please circle one) Patient or Authorized Representative, Parent or Guardian of Minor

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Cherese M. LaPorta D.O., PLLC to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the patient's examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which the patient may have insurance coverage or which may be assisting in payment of the medical care provided by Cherese M. LaPorta D.O., PLLC to the patient. I also hereby authorize Cherese M. LaPorta D.O., PLLC to release any medical information to any licensed physician, healthcare provider, or medical facility to which the patient may be referred admitted or transferred for further medical care.

I understand that I may revoke this authorization by written notice at any time except to the extent that action has been taken.

Signature: ______________________________ **Date:** ________________

(Please circle one) Patient or Authorized Representative, Parent or Guardian of Minor

MEDICAL HISTORY WORKSHEET

Name ________________________________ DOB ___ | ___ | ___

PERSONAL DATA:

Occupation if applicable: ________________________ Education ________________________

Marital Status: (circle one) Single Married Divorced Widowed

Tobacco Product Use:(circle one) None Current Use Past Use Type of Product: ________________

How much per day? ________________________ For how long? ________________________

Daily caffeine consumption? (circle one) Yes No How much per day? ________________

Alcohol Use? (circle one) Yes No How much? ________________________

Do you currently exercise? (circle one) Yes No How often? ____________ What type? ____________

Females: # of pregnancies______ # of live births ________ Type of delivery ________________

MEDICATION ALLERGIES:

NAME OF MEDICATION	REACTION

Do you have any other allergies? (i.e. foods, dyes, environmental, bee stings etc.) ________________

____

MEDICATIONS – PRESCRIPTION & NON-PRESCRIPTION:

NAME	STRENGTH	HOW TAKEN

CURRENT MEDICAL PROBLEMS

	Date of Onset

PAST MEDICAL PROBLEMS / HOSPITALIZATION / SURGERIES

	Dates

FAMILY MEDICAL HISTORY: Please list all relatives diagnosed with any of the following conditions including their age at onset (please note if deceased).

Heart Disease: ______________________

Diabetes: ______________________

High Cholesterol: ______________________

Hypertension: ______________________

Cancer/Type: ______________________

____

____

Mental Health/Depression: ______________________

Other: ______________________

____

SCREENINGS (date of last):

Mammogram: ____________

Pap Smear: ____________

Colonoscopy: ____________

Bone Density: ____________

PSA: ____________

IMMUNIZATIONS (date received):

Tetanus: ____________

Fneumovax: ____________

Influenza: ____________

Hepatitis B: ____________

FPD (Tb skin test): ____________

Do you have a Living Will? Y N **Do you have an Advanced Directive? Y N**

OTHER SPECIALISTS THAT YOU SEE ON A REGULAR BASIS (name and specialty):

____

____

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107 North Ocean Ave
Suite G
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(631) 654-5004

Controlled Substance Agreement
For ALL Controlled Substances

Due to new laws and protocols, we must implement an agreement between my office and you; the patient in order to prescribe any controlled substance. Please read and sign the contract below in order to receive controlled substances from our practice.

1. I understand that controlled substances will only be prescribed by Dr. LaPorta or her designated clinicians on the agreed upon schedule. I will not seek or receive any controlled substances from any other entity without knowledge and permission of Dr. LaPorta and her clinicians. I also understand I must inform any Doctor's that I am receiving controlled substances from.
2. Medication refills will be provided with an appointment via electronical submission, see E-PRESCRIBING CONSENT FORM. No refills will be given prior to the next scheduled appointment date. No show appointments may be cause for terminating the agreement.
3. If recommended to see another specialist or take another form of therapy, I understand it is my obligation to cooperate with these endeavors.
4. I agree to undergo drug testing whenever it is required upon the clinicians discretion. If the drug testing results are positive for illicit drugs or negative for the prescribed prescriptions, this would be considered a breach of the agreement.
5. I agree to fill my prescriptions only at the following pharmacy: ____________________

   ____
6. If I change pharmacies for any reason I will call the healthcare providers office and inform them. I understand that I cannot use more than one pharmacy at any one time.
7. I understand that this agreement may be terminated if I am no longer receiving a reasonable therapeutic benefit from the medication or if it is determined that I am no longer a good candidate to receive the medication(s).
8. I understand that I must follow all precautions on prescriptions; pertaining to driving or operating machinery.
9. I understand that by signing this agreement I must abide by the rules stated above and that failure to abide by this agreement will result in the possible termination of services from my healthcare provider.

Patient Name: ________________________________

Patient Signature: ________________________________

Date: ________________________________

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medications errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribing program. These include:

- **Formulary and benefit transactions**- Give the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**-Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification**- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescriptions has been picked up, not picked up, or partially filled.
- **Medication Refill Policy** – All maintenance medications require an appointment every 3 months. Controlled Substances every month.

By signing this consent form you are agreeing that Dr. Cherese LaPorta, her associates and staff can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Dr. Cherese LaPorta to enroll me in E-Prescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

____

PATIENT NAME

____

PATIENT DATE OF BIRTH

____

SINGNATURE OF PATIENT OR GUARDIAN

____

RELATIONSHIP TO PATIENT

TODAYS DATE: ____________________

ACKNOWLEDGEMENT OF RECEIPT

CHERESE M. LAPORTA, D.O., PLLC

NOTICE OF PATIENT PRIVACY

By my signature below, I hereby acknowledge receipt of the Notice of Privacy Practices, and acknowledge that the Practice will use and disclose my health information for the purpose of treating me, obtaining payment for services rendered to me, and conducting health care operations.

I have also been advised of my rights to obtain access to, and control my Protected Health Information.

______________________________ __________________

Print Name/ Date of Birth Date

X ____

Signature of Patient, Personal Representative, or Parent/Guardian

I give permission to speak with and list their telephone number:

____

____

____

YES or NO you may leave a message on my answering machine.

Answering machine number- ______________________________________