Advanced Parathyroid Surgery of New York

www.advancedparathyroid.com

NEW PATIENT INTAKE

Date: _____

Patient Registration Details							
First Name						SS #	
Last Name							
Address						DOB	
City			State		Zip		
Cell #		Home #		Email			
Reason for Today's Visit							

Language		Employed	☐ Yes ☐ No
Race	☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native		
Ethnicity	☐ Native Hispanic or Latino ☐ Not Hispanic or Latino		
Marital Status		Occupation	

Pharmacy Name		Phone #	
Pharmacy Address			
City		State	
Primary Care Doctor's Name		Phone #	
City		State	
Referring Doctor's Name		Phone #	
City		State	

Insurance Details					
Is the patient the insurance policy holder					
If No - Insurer's Name				SS #	
Relationship to Patient					
Address (if different from above)				DOB	
City		State		Zip	
Primary Insurance Company		Insured's ID			
Address					
City		State		Zip	
Secondary Insurance Company		Insured's ID			
Address					
City		State		Zip	

NAME _____ DATE _____

ALLERGIES

Drugs: ☐ Yes ☐ No (Please List) _____

Other: ☐ Yes ☐ No (Please List) _____

MEDICATIONS: _____

_____

MEDICAL HISTORY: Please check any that apply.

	Myself	Father	Mother	Brothers Sisters	Grand Parents
Allergic Rhinitis					
Anemia					
Anxiety					
Arthritis					
Asthma					
Atrial Fibrillation					
Chest Pain					
Circulatory System Disorder					
Congestive Heart Failure					
Depression					
Diabetes					
Emphysema					
Gout					
Headache					
Hearing Loss					
Heart Attack					

	Myself	Father	Mother	Brothers Sisters	Grand Parents
Heartburn					
Herniated Disc					
High Blood Pressure (hypertension)					
High Cholesterol					
High Lipids					
Hypothyroid					
Insomnia					
Irritable Bowel Syndrome					
Kidney Failure					
Migraine					
Mitral Valve Discorder					
Osteoporosis					
Sinusitis					
Skin Disorder					
Stroke					
Visual Impairment					

Other (Please Describe) _____

_____

SURGERY Date (Mo/Yr) Complications

_____

_____

SOCIAL HISTORY

Alcohol use: ☐ Yes ☐ No Amount (drinks/week) _____ ☐ Beer ☐ Wine ☐ Liquor

Smoker: ☐ Yes ☐ No Packs/day _____ For _____ Years?