JOHN ABROON, M.D.
34 East 72nd Street
New York, New York 10021

Office: 212/288-0900 Fax: 212/988-3973

DATE: ____________

FULL NAME:

____
(PLEASE PRINT CLEARLY)

SOCIAL SECURITY#: ____________________

DATE OF BIRTH (mm/dd/yyyy): ____________

AGE: ______ SEX: ☐ MALE ☐ FEMALE

ADDRESS: ______________________________

____

____
(PLEASE INCLUDE CITY, STATE, & ZIP)

HOME #: ______________________

CELL#: ______________________

At which number may we leave messages concerning test results, office visit confirmations, etc.?

____

E-MAIL: _______________________________

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

Person to contact in case of an emergency: ______________________________

Relationship: ________________ Contact number: ______________________

Employer name and address: ______________________________________

Occupation/Job title: ________________

Work Phone and Extension: ______________ May we contact you at this number during the day? _____

Insurance Plan (and policyholder name, if different): ______________________________

ID/Member No.: ______________________ Group Number: ______________________

Reason for visit: ____

Who referred you to Dr. Abroon? ______________________________________

MEDICAL INFORMATION

HOSPITALIZATION & SURGERY (*if additional space is needed, please let us know*)

Date: ______________ Reason: ____

Date: ______________ Reason: ____

Date: ______________ Reason: ____

Date: ______________ Reason: ____

ALLERGIES (*medications, dyes, foods, etc.*)

____

____

IMMUNIZATION/VACCINATION HISTORY

Hepatitis B	☐ NO	☐ YES	WHEN? ________
Hepatitis A	☐ NO	☐ YES	WHEN? ________
Tetanus	☐ NO	☐ YES	WHEN? ________
Flu Vaccine	☐ NO	☐ YES	WHEN? ________
Pneumonia	☐ NO	☐ YES	WHEN? ________
Measles	☐ NO	☐ YES	WHEN? ________
Mumps	☐ NO	☐ YES	WHEN? ________
Rubella	☐ NO	☐ YES	WHEN? ________
Shingles	☐ NO	☐ YES	WHEN? ________

LIFESTYLE

Alcohol:	☐ NO	☐ YES	FREQUENCY ________
Smoke:	☐ NO	☐ YES	FREQUENCY ________
Drug use:	☐ NO	☐ YES	FREQUENCY ________
Coffee/Caffeine:	☐ NO	☐ YES	FREQUENCY ________
Difficulty Sleeping:	☐ NO	☐ YES	FREQUENCY ________
Exercise:	☐ NO	☐ YES	FREQUENCY ________

Briefly describe your diet:

____

____

____

____

MEDICATIONS (*prescription, over-the-counter, herbs, vitamins, etc.*)

Drug Name and Dose:

____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________

FAMILY HISTORY

	Parents	Siblings
High Cholesterol	☐	☐
Heart Disease	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Mental Illness	☐	☐
Stroke	☐	☐
Alcoholism	☐	☐
Depression	☐	☐
High blood pressure	☐	☐
Other: ________	☐	☐

Comments: _____________________________________

____

PAST MEDICAL HISTORY

PLEASE CIRCLE IF YOU HAVE HAD PROBLEMS WITH OR ARE EXPERIENCING ANY OF THE FOLLOWING:

- High blood pressure
- Low blood pressure
- High cholesterol
- Blood in urine
- Blood in stool
- Hemorrhoids
- Frequent urination
- Kidney disease
- Gallbladder disease
- Thyroid disease
- Diabetes
- Weight gain
- Weight loss
- Difficulty losing weight
- Loss of appetite
- Depression
- Sexual dysfunction
- Memory loss
- Anxiety/Stress
- Dizziness/Fainting
- Anemia
- Nausea/Vomiting
- Indigestion/Acid reflux
- Chest pain
- Palpitations
- Heart murmur
- Asthma
- Bronchitis
- Hernia
- Arthritis
- Osteoporosis
- Leg pain/Walking pain
- Back problems
- Chronic sinusitis
- Seasonal allergies
- Sore throat
- Headaches
- Fever
- Ear infections
- Eye disease
- Hepatitis/Jaundice
- Cancer (type and year diagnosed): ____________________

PLEASE SUPPLY LATEST DATES:

Prostate exam: ____________
Cholesterol test: ____________
Pap smear: ____________
Stool check: ____________

FEMALE PATIENTS, PLEASE COMPLETE:

Are you pregnant? ____________
Are you planning pregnancy? ____________
Is your menstrual flow regular or irregular? ____________
Do you take birth control? ____________

THIS INFORMATION IS FOR USE BY YOUR PHYSICIAN AS PART OF YOUR CONFIDENTIAL MEDICAL RECORD.

PATIENT RESPONSIBILITY

I, ______________________________, understand I am responsible in making arrangements with my insurance carrier in selecting Dr. John Abroon as my primary care physician *prior to my office visit*. I will be held responsible for payments of services rendered by Dr. Abroon if my insurance carrier fails to pay.

Patient signature: ______________________ Date: ____________________

Thank you for visiting our office! Please let us know if you have any questions or concerns related to your visit.

JOHN ABROON, M.D.
34 East 72nd Street
New York, New York 10021

Office: 212/288-0900 Fax: 212/988-3973

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this *Notice of Privacy Practices* and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF *Notice of Privacy Practices* FOR PROTECTED HEALTH INFORMATION

Dated: _________, 20__
New York, New York

____
Signature of Patient or Representative

____
Patient's Printed Name

____
Printed name of personal representative (if applicable)

____
Relationship to the patient (if applicable)

PATIENT RESPONSIBILITY

As of January 1, 2014 new healthcare rules and regulations have come into effect. Therefore please check with your insurance carrier and/or Human Resources department to further understand your healthcare coverage and payment responsibilities, including but not limited to any deductibles and/or coinsurance, as they may have changed.

I, ___________________________________, understand and agree that that I assume full financial responsibility for services rendered to me by Dr Abroon, if my insurance carrier denies or does not cover my claim for these services, or if my insurance carrier does not pay Dr Abroon in a timely manner (within 60 days).

I also understand that I am fully responsible for, any deductible/coinsurance payment due under my insurance contract, in a timely manner (no more than 30 days after I have been notified by my insurance carrier and/or provider), and for any co-payment at the time of service.

I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

Patient Signature: _______________________________________

Date:________________________________