

ARTHUR H. KATZ, M.D., S.C.

PLEASE PRINT

Please Fill Out Completely

PATIENT NAME: _____

DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____

CELL PHONE: _____

EMERGENCY CONTACT NAME & RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____

PHONE NUMBER & ADDRESS: _____

REFERRING PROVIDER: _____

PHONE NUMBER & ADDRESS: _____

PRIMARY INSURANCE _____

~~SECONDARY INSURANCE~~ _____

EMAIL ADDRESS: _____

PLACE OF EMPLOYMENT _____ RETIRED _____

EMPLOYER PHONE NUMBER: _____ UNEMPLOYED _____

GUARANTOR INFORMATION

NAME: _____ ADDRESS: _____

RELATIONSHIP: _____

PHONE NUMBER: _____

SIGNATURE: _____

DATE: _____

Arthur H Katz M.D., S.C.

Acknowledgement of Receipt and/or Review of Privacy Practices

In an effort to communicate with you more effectively and keep your Protected Health Information confidential, we are asking that you complete the following form. This form lets you decide who we can release your information to and for what reason. If you have any questions about this form, please ask.

I, _____ have either received a paper copy or reviewed the office copy of Dr. Katz, MD, Notice of Privacy Practices.

Dr. Katz or his staff may discuss or leave information about my Protected Health Information and/or financial matters to the people listed below.

Name: _____ Relation: _____ Phone#: _____

Name: _____ Relation: _____ Phone#: _____

Name: _____ Relation: _____ Phone#: _____

In addition to the above, how may we communicate to you regarding any health issues or concerns which may be confidential? (For example: Lab Results, X-rays, Reminders of appointments, etc.) PLEASE ANSWER EVERY QUESTION BELOW.

~~Mailed (sealed privacy mail only)~~

~~Yes~~ _____ ~~No~~ _____

Can we leave a message on an answering machine?

Yes _____ No _____

Can you be contacted at work?

Yes _____ No _____

(If so, please provide us with a phone#)

_____ ext. _____

Cell Phone

Yes _____ No _____

Phone Number if available

Other: _____

Patient/Responsible Party Date: _____

If responsible party, relation to patient

Patient Name _____ Date _____

Medical History

Alcohol Use	Yes	No	High Blood Pressure	Yes	No
Allergies/Hay Fever	Yes	No	HIV Positive or AIDS	Yes	No
Arthritis	Yes	No	Kidney Disease	Yes	No
Asthma	Yes	No	Liver Disease	Yes	No
Cancer	Yes	No	Lung Disease	Yes	No
Diabetes	Yes	No	Meningitis	Yes	No
Drug Use	Yes	No	Multiple Sclerosis	Yes	No
Elevated Cholesterol	Yes	No	Osteoporosis	Yes	No
Fainting or Dizzy Spells	Yes	No	Psychiatric Treatment	Yes	No
Gerd	Yes	No	Sinus Disease	Yes	No
Glaucoma	Yes	No	Smoker	Yes	No
Headaches	Yes	No	Stroke	Yes	No
Heart Problems	Yes	No	Thyroid Disease	Yes	No
Hepatitis (Jaundice)	Yes	No	Ulcer (Stomach)	Yes	No

Do you snore or have sleep apnea? _____

Have you had a sleep study done? _____ Where: _____ When: _____

Did you have your tonsils or adenoids removed? _____ Where: _____ When: _____

Do you have difficulty breathing through your nose? _____

Do you frequently have heartburn, acid reflux, or have been diagnosed with GERD? _____ Yes No

Previous Surgeries or Hospitalizations (last 10 years only) _____

Skin Diseases

~~Do you feel that your skin has suffered damage due to over-exposure to the sun?~~ _____ Yes No

~~After sun exposure, has your skin ever blistered or peeled?~~ _____ Yes No

Do you have an irregular growth or growths on your skin? _____ Yes No

If you answered YES to the last question, please answer the following:

Do you have an area on your skin that is (circle any that apply): _____

raised/glat/spotted/mole/wart/cyst/ or a dark pigmented lesion? _____ Yes No

Is there more than one questionable area? _____ Yes No

Where is it located (circle all that apply): _____

face/nose/ears/neck/chest/backabdomen/arms/hands/legs/feet/buttocks _____ Yes No

How long have you had it? Date/Years if known: _____

Has it changed in size or shape? _____

Have you ever had a mole/lesion removed? _____ How many? _____ Location: _____ Yes No

Primary Care Physician: _____ Phone# _____

Pharmacy/Town: _____ Phone# _____

I saw Dr. Katz's listing in the Yellow Pages Directory: _____ Yes No

I saw Dr. Katz's listing on the internet _____ Yes No

Other: _____

Patient Name _____ Date _____

Medication Information

Current Medications. Include all prescription, over-the-counter medications, vitamins, and diet aids.

Name	Dose	Name	Dose

Please list any Food or Medication Allergies

Please circle any of the following medications you have tried

<u>Pill</u>	<u>Did it help?</u>	<u>Nasal Spray</u>	<u>Did it help?</u>
Allegra	Yes No	Astelin (Azelastine)	Yes No
Allegra D	Yes No	Flonase (Fluticasone)	Yes No
Clarinet	Yes No	Nasonex	Yes No
Claritin	Yes No	Atrovent (Ipratropium Bromide)	Yes No
Claritin D	Yes No	QNasil	Yes No
Singulair (Montelukast)	Yes No		
Zyrtec	Yes No		
Zyrtec D	Yes No		
<u>Asthma/Inhaler</u>	<u>Did it help?</u>	Comments on any of these Medications: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> 	
Advair	Yes No		
Albuteral	Yes No		
Asmanex	Yes No		
Azmacort	Yes No		
Flovent	Yes No		
Foradil	Yes No		
Proventil	Yes No		
Pulmicort	Yes No		
Serevent	Yes No		
Singulair	Yes No		
Xopenex	Yes No		
Spiriva	Yes No		
Combivent	Yes No		

Please list any over the counter, prescription, herbal or other medication you have tried.

Name	Did it help?	Name	Did it help?
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