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: _____

_____ Date: _____

Patient/Responsible Party

_____

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? _____

Previous Surgeries or Hospitalizations (last 10 years only) _____

_____

Current Medications and medical treatments _____

_____

_____

_____

_____

Have you ever responded adversely to any medical treatment? If yes, list treatment

_____

_____

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: _____

Email: _____

Patient Name: _____ Date: _____

Sleep Apnea Risk

Do you snore or have you been told you snore? Yes No
Does someone in your household snore? Yes No
Who? _____
Did you have your tonsils removed? Yes No Year _____
Do you have any difficulty breathing through your nose? Yes No
Does your nose block frequently? Yes No
Is there a family history of sleep apnea? Yes No
Do you frequently have heartburn, acid reflux, or have been diagnosed with GERD? Yes No
Have you ever had a sleep study done or been diagnosed with sleep apnea? Yes No
Where? _____ When: _____
Please circle all that apply to you:

Anxiety
Depression
Forgetfulness
Irritability
Lack of Concentration

Skin Cancer Risk

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 body that is: (circle any that apply)
raised/flat/spotted/mole/wart/cyst/ or a dark pigmented lesion? Yes No
Is there more than one questionable are? Yes No
Where is it located? (circle any that apply)
face/nose/ears/neck/chest/back/abdomen/arms/hands/legs/feet/buttocks
How long have you had it? Date/Year if known _____
Has it changed in color/shape/size? Yes No
Have you ever had a mole/lesion removed? Yes No
How many? _____ Where was it located? _____
Did it scar or keloid (raise)? Yes No
Was it cancerous? Yes No

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

Pill	Did it help?		Nasal Spray	Did it help?	
Allegra	Yes	No	Astelin	Yes	No
Allegra D	Yes	No	Flonase	Yes	No
Clarinex	Yes	No	Nasacort AQ	Yes	No
Claratin	Yes	No	Nasonex	Yes	No
Claratin D	Yes	No	Rhinocort AQ	Yes	No
Singulair	Yes	No			
Zyrtec	Yes	No			
Zyrtec D	Yes	No			

Chest Medicine/Inhaler		**Did it help?**
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

Comments on any of these Medications:

_____

_____

_____

_____

_____

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

Name	**Did it help?**	**Name**	**Did it help?**