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 matter 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

Condition			Condition		
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? Yes No

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? Yes No

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

Pill	Did it help?	
Allegra	Yes	No
Allegra D	Yes	No
Clarinex	Yes	No
Claritin	Yes	No
Claritin D	Yes	No
Singulair (Montelukast)	Yes	No
Zyrtec	Yes	No
Zyrtec D	Yes	No

Asthma/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
Spiriva	Yes	No
Combivent	Yes	No

Nasal Spray	Did it help?	
Astelin (Azelastine)	Yes	No
Flonase (Fluticasone)	Yes	No
Nasonex	Yes	No
Atrovent (Ipratropium Bromide)	Yes	No
QNasil	Yes	No

Comments on any of these Medications:

____

____

____

____

____

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

Name	Did it help?	Name	Did it help?

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

Please Print

Patient Name: ____

Date of Birth: ____

Street Address: ____

City, State, Zip: ____

Phone: (H) _______________________ (C) __________________________

Primary Care Physician: ______________________________________

Phone Number & Address: ____________________________________

Referring Provider: ____

Phone Number & Address: _____________________________________

Primary Insurance& Policy Holder: ____________________________

Policy Holder DOB: ______________________________________

Secondary Insurance& Policy Holder: __________________________

Policy Holder DOB: ______________________________________

Email Address: ____

Signature: ____ Date: ___________