JOSEPH MULVEHILL, M.D.
10 EAST 78TH STREET, SUITE B1
NEW YORK, NY 10075

INTERNAL MEDICINE
TIN: 13-4201408

TEL: 212.737.3136
FAX: 212.737.8143

PATIENT DEMOGRAPHICS

Patient's Name: _____ (last) _____ (first) _____ (mi)

Address: _____ (street) _____ (apt. no.)

_____ (city) _____ (st) _____ (zip)

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Date Of Birth: _____ SSN: _____ Sex: ☐ M ☐ F

E-mail: _____

home: _____

cell: _____

work 1: _____ X _____

work 2: _____ X _____

GUARANTOR INFORMATION

Guarantor's Name: _____ (last) _____ (first) _____ (mi)

Address: _____ (street) _____ (apt. no.)

_____ (city) _____ (st) _____ (zip)

Date Of Birth: _____ SSN: _____

Sex: ☐ M ☐ F Relationship to Patient: Self

home: _____

cell: _____

work 1: _____ X _____

work 2: _____ X _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ (last) _____ (first)

Relationship to Patient: Self

home: _____

cell: _____

work 1: _____ X _____

work 2: _____ X _____

INSURANCE INFORMATION

Insured's Name: _____ (primary subscriber name(last)) _____ (primary subscriber name(first))

_____ (primary insured's date of birth) Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Insurance Company: _____ (company name) _____ (policy number) _____ (group number) _____ (copay)

SECONDARY INSURANCE INFORMATION

Insured's Name: _____ (primary subscriber name(last)) _____ (primary subscriber name(first))

_____ (primary insured's date of birth) Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Insurance Company: _____ (company name) _____ (policy number) _____ (group number) _____ (copay)

Assignment of Benefits and Waiver of Liability (YOU MUST SIGN BOTH LINES)

I hereby authorize the release of medical information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further authorize payment for all billed services to be made directly to Joseph Mulvehill, M.D.. I understand and agree to be financially responsible for any balance not covered by my insurance plan.

_____ Signature of Subscriber or Spouse _____ Date

I, the undersigned have agreed to provide Joseph Mulvehill, M.D. with the necessary referrals and documents to bill my insurance plan. If I elect to be seen without a referral, I agree to accept financial responsibility for all charges incurred. If the referral I provide is not valid for the services rendered, or if I have failed to register Joseph Mulvehill, M.D. as my PCP with my HMO, I will be responsible for all balances due to Joseph Mulvehill, M.D.. I accept this responsibility on behalf of myself and/or my dependents.

_____ Signature of Subscriber or Spouse _____ Date

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THIS POLICY MUST BE SIGNED BY THE PATIENT IN ORDER TO SEE DR. MULVEHILL.

FINANCIAL POLICY ACKNOWLEDGEMENT

We are dedicated to providing you with the best possible care and service, and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our staff.

• Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you provided you assign benefits to the doctor (i.e., you agree to have the insurance company pay the doctor directly, rather than reimburse you for payment made at the time of service). If your insurance company does not pay the doctor within a reasonable period, we will have to look to you for payment.

• Every health plan is different and not all plans cover the same services. In the event that you are not covered for a particular service, you will be responsible for the complete charge. Patients are encouraged to contact their carriers for clarification of benefits prior to services being rendered. Charges for travel vaccinations (Hepatitis A, Japanese Encephalitis, Rabies, Typhoid and Yellow Fever) will not be billed to insurance companies as a standard office practice and payment for these is the sole responsibility of the patient.

• Patients are responsible for informing the office of all changes in insurance coverage and all requirements for referrals and authorizations. Any charges denied as a result of your failure to inform us of a change will be billed to you. Additionally, we require at least three business days notice to process referrals to other doctors' offices. Referrals **will not** be post-dated or processed same day.

• Past due accounts are subject to collection proceedings. All fees, including but not limited to collection fees, attorney's fees and court fees, shall become your responsibility in addition to any balance due to our office.

• Please be advised that we require no less than 24 business hours notice whenever a routine appointment is cancelled, and no less than 48 business hours notice whenever a new patient appointment or procedure is cancelled. Patients are billed for no-show and late cancellation appointments, at a rate of $25 for routine appointments and $50 for new patient appointments and procedures. Insurance companies are not responsible for payment of no-show and late cancellation bills. In the event that you realize during the weekend that you won't be able to make an appointment the following week, please call the office and leave a message canceling your appointment. Please also call Monday morning after 9:00 am to verify that we have received the message.

• All payments and co-payments are due at the time of service to avoid a $5.00 surcharge, and all returned checks will be subject to a $30.00 surcharge. Your insurance company does not cover these surcharges

• Patients are required to present their insurance card every time they come in to see Dr. Mulvehill.

Thank you in advance for your cooperation.

Patient's full name	Patient's signature	Date
Witness' full name	Witness' signature	Date

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Joseph Mulvehill, M.D., 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 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, Dr. Mulvehill, and staff.

Full name of Patient or Personal Representative	Signature of Patient or Personal Representative	Date
Full name of Witness	Signature of Witness	Date

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REVIEW OF SYSTEMS

Patient Name: , _____ Date of Birth: _____ Appt. Date: _____

Please complete the following questions concerning your past and present health and the health of your family:

What are your current health concerns? _____

_____

_____

_____

During the last five years, have you regularly visited a doctor? ☐ Yes ☐ No
If yes, please provide the name, address and telephone number:

_____

Do you regularly visit the dentist? ☐ Yes ☐ No
If yes, please provide the name, address, and telephone number:

_____

FEMALE PATIENTS:

Do you regularly visit the gynecologist? ☐ Yes ☐ No
If yes, please provide the name, address, and telephone number:

_____

Date of last Pap smear: _____ **Normal result?** ☐ Yes ☐ No

If no, please provide detail: _____

FEMALE PATIENTS OVER 40:

Have you had a mammogram? ☐ Yes ☐ No

If yes, please provide detail of the results: _____

MALE PATIENTS:

Have you had a Prostate Specific Antigen (PSA) test? ☐ Yes ☐ No

If yes, please provide detail of the results: _____

Do you have allergies to any of the following?

☐ Penicillin ☐ Other drugs (list: _____)

☐ Foods (list: _____)

Have you ever had an allergic reaction to a vaccine? ☐ Yes ☐ No

If yes, please describe: _____

Please indicate which of the following vaccinations you have had by placing a mark in the box, and indicate when you had the vaccination on the line provided. If you cannot remember the exact date or year, an estimate is acceptable:

☐ Hepatitis A	_____	☐ Rabies	_____
☐ Hepatitis B	_____	☐ Tetanus/Diphtheria	_____
☐ Japanese Encephalitis	_____	☐ Typhoid	_____
☐ Measles/Mumps/Rubella	_____	☐ Yellow Fever	_____
☐ Polio	_____		

Patient Name: , _____ Appointment Date: _____

MEDICATIONS

Please list all prescription drugs you are currently taking:

	Medication	Dose	How often?		Medication	Dose	How often?
1.				5.			
2.				6.			
3.				7.			
4.				8.			

Please list all non-prescription drugs (including aspirin/other painkillers, cold medicines, sleep aids, laxatives, herbs/holistic remedies) you are currently taking:

	Medication	Dose	How often?		Medication	Dose	How often?
1.				5.			
2.				6.			
3.				7.			
4.				8.			

MAJOR ILLNESSES/SURGERY/HOSPITALIZATIONS

	Problem	Year	Place of treatment	Length of hospitalization
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

SEXUAL ACTIVITY

Are you currently sexually active? ☐ Yes ☐ No

Do you use contraceptives? ☐ Yes ☐ No If yes, what method? _____

SMOKING

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs/day for how long?

_____

Have you smoked in the past? ☐ Yes ☐ No If yes, how many packs/day for how long, and when did you quit?

_____

ALCOHOL USE

On average, how much of the following do you consume?

	Daily	Weekly
Beer		
Wine		
Liquor		

Patient Name: , _____ Appointment Date: _____

CONSTITUTIONAL

Do you have trouble with your appetite? ☐ Yes ☐ No
Have you had more than a ten pound weight change in the last year? ☐ Yes ☐ No
Do you have any fevers or sweats? ☐ Yes ☐ No

SKIN

Do you have any skin rashes, sores or itching? ☐ Yes ☐ No
Do you have any moles or beauty marks that are changing or troubling you? ☐ Yes ☐ No

EAR/NOSE/THROAT

Do you have eye problems or trouble with your vision? ☐ Yes ☐ No
Do you have any problems with your ears or your hearing? ☐ Yes ☐ No
Do you have any trouble with your teeth, gums, mouth or throat? ☐ Yes ☐ No
Do you have any sinus trouble? ☐ Yes ☐ No

RESPIRATORY

Do you have a persistent cough or phlegm production? ☐ Yes ☐ No
Do you have any wheezing? ☐ Yes ☐ No
Do you ever cough up blood? ☐ Yes ☐ No

CARDIAC

Do you have trouble breathing? ☐ Yes ☐ No
Do you ever have pain or tightness in your chest? ☐ Yes ☐ No
Do your ankles swell? ☐ Yes ☐ No

GASTROINTESTINAL

Do you have any difficulty swallowing? ☐ Yes ☐ No
Do you have any stomach pains, heartburn or vomiting? ☐ Yes ☐ No
Do you have constipation or use a laxative often? ☐ Yes ☐ No
Do you have frequent diarrhea? ☐ Yes ☐ No
Have you ever had any tarry, black or bloody bowel movements? ☐ Yes ☐ No
Has there been any recent change in the color, size or consistency of your bowel movements? ☐ Yes ☐ No
Do you have rectal hemorrhoids? ☐ Yes ☐ No

GENITOURINARY

Do you get up more than once a night to urinate? ☐ Yes ☐ No
Do you experience any burning sensation with urination? ☐ Yes ☐ No
Have you passed any red or dark urine? ☐ Yes ☐ No
Do you have any trouble starting or stopping your urine? ☐ Yes ☐ No
Do you ever lose your urine accidentally? ☐ Yes ☐ No

MUSCULOSKELETAL

Are you bothered by pains in your back, arms, legs or joints? ☐ Yes ☐ No
Do you have any numbness, tingling or weakness in your arms or legs? ☐ Yes ☐ No

NEUROLOGIC/HEMATOLOGIC

Are you bothered by frequent headaches? ☐ Yes ☐ No
Do you have fainting spells? ☐ Yes ☐ No
Do you bleed easily? ☐ Yes ☐ No

MALE SEXUAL

Do you examine your testicles monthly? ☐ Yes ☐ No
Do you have any discharge or drip from your penis? ☐ Yes ☐ No
Do you have a sore or lump on or near your penis? ☐ Yes ☐ No

FEMALE SEXUAL

Do you examine your breasts monthly? ☐ Yes ☐ No
Do you have any breast lumps, discharge or pain? ☐ Yes ☐ No
Are you bothered by vaginal itching? ☐ Yes ☐ No

EMOTIONAL

Do you often feel depressed or sad? ☐ Yes ☐ No
Are you upset or nervous more than you feel you should be? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No
Have you had any serious trouble with your memory? ☐ Yes ☐ No

Patient Name: , Appointment Date: _____

PAST MEDICAL HISTORY AND FAMILY HISTORY

If you or any other members of your family have had any of the following conditions, please indicate who has had them by checking the appropriate boxes. If the condition caused the death of any relative(s), indicate the relation(s) in the "Cause of Death" column, as well as their age(s) at the time of death.

	Yourself	Father	Mother	Sibling	Grandparent	Child	Other	Cause of Death	Age at Death
Alcoholism									
Anemia									
Sickle Cell disease									
Asthma/Hayfever									
Bronchitis									
Emphysema									
Pneumonia									
Tuberculosis									
Arthritis/Gout									
Blood transfusions									
Cancer									
Diabetes									
Gallbladder disease									
Heart Disease									
Heart murmur									
Rheumatic fever									
Hepatitis									
Colitis									
High blood pressure									
Kidney disease/stones									
Urinary infections									
Mental illness									
Mental retardation									
Seizures/epilepsy									
Stroke									
Glaucoma/blindness									
Ulcers									
Sexually transmitted disease(s)									
Obesity									
HIV disease (AIDS)									
Migraine headaches									
Thyroid disease									
Any other (specify below)									