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

JOSEPH MULVEHILL, M.D.
10 EAST 78TH STREET, SUITE 1B
NEW YORK, NY 10075

INTERNAL MEDICINE

TEL: 212.737.3136
FAX: 212.737.3481

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

JOSEPH MULVEHILL, M.D.
10 EAST 78TH STREET, SUITE 1B
NEW YORK, NY 10021

INTERNAL MEDICINE

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TRAVEL REVIEW OF SYSTEMS

Patient Name: , _____ Date of Birth: _____ Appointment Date: _____

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

What countries are you planning to visit? _____

_____

Why are you traveling?

☐ Leisure ☐ Adventure ☐ Business
☐ Visiting friends/family ☐ Military ☐ Airline crew
☐ Expedition ☐ Extended travel/living abroad ☐ International adoption
☐ Missionary work ☐ Peace Corps

Do your plans include:

☐ Excursions or side trips ☐ Sporting events ☐ Safari
☐ Handling animals ☐ A trip to the beach ☐ Hiking/backpacking
☐ Whitewater rafting

Do you plan to go swimming?

☐ Chlorinated swimming pool ☐ Freshwater lake/river/stream ☐ Ocean

Do you plan to travel to or climb to high altitudes? ☐ Yes ☐ No

What are your current travel concerns? _____

_____

Please list all foreign countries you have visited or resided in over the past 10 years, starting with the most recent:

1. _____ **6.** _____
2. _____ **7.** _____
3. _____ **8.** _____
4. _____ **9.** _____
5. _____ **10.** _____

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

_____

Are you up to date on all of your vaccinations/boosters? ☐ Yes ☐ No

Do you have allergies to any of the following?

☐ Penicillin ☐ Other drugs (list: _____)
☐ Insects/bees ☐ Foods (list: _____)

Have you ever had an allergic reaction to egg or egg products? ☐ Yes ☐ No

Have you ever fainted after receiving a shot? ☐ Yes ☐ No

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

If yes, please describe: _____

Patient Name: , _____ Appointment Date : _____

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	_____		

MEDICATIONS: Please list all prescription and over the counter drugs you are currently taking:

	Medication	Dose	How often?		Medication	Dose	How often?
1.	_____	_____	_____	6.	_____	_____	_____
2.	_____	_____	_____	7.	_____	_____	_____
3.	_____	_____	_____	8.	_____	_____	_____
4.	_____	_____	_____	9.	_____	_____	_____
5.	_____	_____	_____	10.	_____	_____	_____

MAJOR ILLNESSES/SURGERY/HOSPITALIZATIONS

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

IMMUNO-COMPROMISED PATIENTS: Please mark all that apply:

☐ Spleen removed	☐ Transplant recipient	☐ Radiation/Chemotherapy
☐ Cirrhosis of the liver	☐ Lupus	☐ HIV/AIDS

OTHER MEDICAL HISTORY: Please mark all that apply:

☐ Thymus disease or surgery	☐ History of myasthenia gravis	☐ History of motion sickness

SEXUAL ACTIVITY

Are you currently sexually active? ☐ Yes ☐ No

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

WOMEN PATIENTS: Please mark all that apply:

☐ Currently pregnant (due date: _____)	☐ Plan to become pregnant within 3 months
☐ Breastfeeding (age of baby: _____)	☐ History of recurrent urinary tract infections

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

	Daily	Weekly
Beer	_____	_____
Wine	_____	_____
Liquor	_____	_____

Patient Name: , Appointment Date:

PAST MEDICAL HISTORY

If you have had any of the following conditions, please indicate by checking the appropriate box. Put any additional information the Comments section. List any additional conditions at the bottom of the page.

	Yes	No	Comments
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)			