

PATRICIA C. MCCORMACK, M.D, F.A.A.D

1550 Richmond Ave., Suite 207
Staten Island, NY 10314
Phone: 718-698-1616

407 Richmond Ave.
Point Pleasant Beach, NJ 08742
Phone: 732-295-1331

822 North Wood Ave.
Linden, NJ 07036
Phone: 908-925-8877

Today's Date: ____/____/____ Date of Birth: ____/____/____ Male___ Female___

Last Name, First Name: _____

Address: _____

City: _____ State _____ Zip _____

Home: () _____ Work: () _____ Cell: () _____

Age: _____ S.S.# _____

Person responsible for bill: _____

Relationship to patient: _____ S.S.# _____

Employer name & address: _____ Phone# _____

IN CASE OF EMERGENCY NOTIFY: _____

Relationship: _____ Phone# _____

Primary Care Physician: _____ **Phone#** _____

Address: _____ **Town:** _____

Pharmacy: _____ **Town:** _____ **Phone#** _____

ALL PATIENTS MUST PROVIDE THE FOLLOWING INFORMATION:

Reason for visit: _____

1. Do you have **allergies**? _____ if so, please explain _____

2. Are you allergic to **lidocaine**? Y___N___ **Latex**? Y___N___ **Heart condition**? Y___N___

3. Please list all medications you are currently taking. Include OTC and prescriptions, herbal supplements, cough medicines, laxatives, and suppositories: _____

Have you had any operations? _____ If so, please describe _____

Have you ever been hospitalized? _____ If so, please list year and medical condition _____

Have you ever been diagnosed or treated for any of the following:

High blood pressure	Kidney disease	Migraines or headaches	Eye disease	Hives/Urticaria
Diabetes	Liver disease	Excessive bleeding	Hay fever	Hypertrophic/Keloid scars
Heart disease	Endocrine disease	Blood disorder	Acne	Herpes
Lung disease	Thyroid disease	Lupus/Anemia	Psoriasis	AIDS risk
Gastro-intestinal disease	Seizures	Arthritis	Eczema	Cancer

Please list any other medical condition that you would like the doctor to be aware of: _____

FOR WOMEN:

A. Are you on birth control? _____

Which type: _____

B. Last menstrual period? ____/____/____

C. Are you pregnant? _____

D. Are you breastfeeding? _____

If so, when do you anticipate you will stop breastfeeding? _____

HABITS:

A. Do you consume alcohol? _____

B. Other substances? _____

C. Do you smoke? _____

D. Do you exercise? _____

Assignment of insurance benefits*Authorization to release information***:**

I hereby authorize direct payment of surgical/medical benefits to Dr. Patricia McCormack for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by insurance. I also authorize Dr. McCormack to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payments of authorized benefit be made on my behalf.

Name: (print) _____ Signature _____

Parent/guardian: _____ Signature _____

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REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PATIENTS PLEASE NOTE:

The practice is not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests.

Patient Name: _____ DOB _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Please mark where you **DO NOT** want us to contact you:

(If no restrictions, please check “**NO RESTRICTIONS**” and sign below)

- Home phone
- Home address
- Work phone
- Work address
- Spouse’s work
- Other _____
- **NO RESTRICTIONS** _____

Please mark any information that may not be shared with your other physicians, pharmacy, or your insurance company:

- Occupation
- Name of employer
- Visit notes/hospital notes
- Prescription information
- Patient history
- Other _____
- **NO RESTRICTIONS** _____

****PAYMENT AND/OR CLAIMS MAY BE DENIED IF CERTAIN INFORMATION IS RESTRICTED TO YOUR INSURANCE COMPANY****

Do you have any special instructions or requests concerning your personal health information?

Signature of Patient or Legal Guardian

Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED OR OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTAND THE NOTICE

Print Name

Date

Parent or Authorized Representative

Date

Signature

Date

****Note****

This acknowledgement shall remain valid for a period of six (6) years from date of signing.

If you would like to review, read, or take a copy of the notice of privacy practices, please ask a member of Dr. McCormack's staff.