NYU Winthrop
Medical Affiliates

NYU Winthrop Medical Affiliates Patient Demographic Form

Patient Information

Name (Last, First, MI)			Email address
Street Address	City	State	Zip
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐		Cell Phone ( ) Preferred ☐
SSN	Date of Birth	Gender ☐ Male ☐Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner ☐ Other
Race	Ethnicity	Preferred Language	Country of Origin

Financially Responsible Party

Is patient responsible party/guarantor? ☐Yes☐No(If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)

Name	Address	City/State/Zip	Relationship to Patient
Occupation	Employer	Email Address	Date of Birth
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐		Cell Phone ( ) Preferred ☐

Emergency Contact

Name		Relationship to Patient
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

Referral Info

Referring Physician's Name	Physician Phone/Fax (if known) ( )
Physician Address	

PCP Info

Primary Care Physician's Name (Check if same as Referring Physician above☐)	Physician Phone/Fax (if known) ( )
Physician Address	

Insurance Information

Primary Insurance Company	Policy #	Group #	
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Name of Subscriber (if other than patient)		
Subscriber's Social Security #	Gender ☐ Male ☐Female	Date of Birth	Employer of Subscriber / Work Phone ( )
Secondary Insurance Company	Policy #	Group #	
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Name of Subscriber (if other than patient)		
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber / Work Phone ( )

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: ____/____/____

Guarantor Signature (if other than patient): _____ Date: ____/____/____

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Pharmacy Information

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions. In addition, when you run out of refills on your medication, the pharmacist can now electronically send renewal requests to this office for approval.

**Note: Controlled medications are not eligible for e-prescribing.

Please complete the information below if you are interested in e-prescribing.

Patient Name: _____

Preferred Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Alternate Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Laboratory Information

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to NYU Winthrop laboratory.**

LabCorp	
Quest Labs	
NYU Lab	
Sunrise Laboratory	
Other External Location	

Please provide name of external location: _____

NYU Langone Health

NYU Langone Health
Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

By signing this form, I acknowledge that I have received a copy of NYU Langone Health's Notice of Privacy Practices.

Patient Name: _____

Signature: _____ **Date:** _____

Personal Representative's Name (if applicable): _____

Personal Representative's Authority (e.g., parent, guardian, health care proxy):

_____

Effective as of 11/01/2017.

HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:
Please check Box 1 or 2:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

Print Name of Patient	Patient Date of Birth
Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

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Patient Information Change/Verification Form

CURRENT DEMOGRAPHICS	
Today's Date:	
Patient's Legal Name:	(Last, First, Middle)
Date of Birth:	
Sex:	
Email:	
Phone Number:	
Address:	

PREVIOUS DEMOGRAPHICS	
Patient's Previous Name:	
Previous Address:	

If necessary, provide complete SSN: _____-____-_____

Relationship to the patient: (circle one) Self - Parent - Legal Guardian

For Minors, verify parent/guardian name: _____
(Please provide parent's Photo ID to scan)

_____

Signature

_____

Print Name