PATIENT INFORMATION FORM

New York Specialists In Medical Weight Control

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www.TitleMD.com

Patient Name: (Last)_____(First)_____(MI)___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Birthdate: _____ Age: _____ Sex: M F

Referred by: _____

EMPLOYMENT INFORMATION:

Occupation: _____ Employer: _____ Work Phone #: _____

IN CASE OF EMERGENCY:

Name: _____Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

FAMILY HISTORY:

Relative - Illness: _____

_____

CURRENT MEDICINES / VITAMINS: _____

_____

_____

ALLERGIES: _____

PAST MEDICAL HISTORY:

Operations / Surgeries: _____

_____

Illness / Sickness: _____

_____

PATIENT SIGNATURE: **X**_____**X** **Date:** _____

Nutritional Review

- How often do you **smoke**? _____
- What **alcoholic** beverages do you drink? _____
- How often do you drink the above? _____
- Do you drink **Coffee or Tea**? _____
- How may cups per day? _____
- Do you get palpitation or nervousness after drinking coffee or tea? _____
- How many hours do you **sleep** nightly? _____
- Do you have insomnia or difficulty sleeping? _____
- What time do you: Go to sleep? _____
  Awake in the morning? _____
- Are you involved in any form of regular **exercise**?
  (If yes, what type & how often):
  _____
- Do you feel you have a good understanding of what is proper nutrition? _____
- Is your present weight stable? _____
- Does obesity run in your family? _____
- Do you have to be careful to keep your weight stable?____
- What was your **weight at age**:
  15 _____ 25 _____ 35 _____ 45 _____
- Weight gain started at age: _____
- Amount gained last 3 months: _____
  6 months: _____
- Are you now on a **diet**? (If yes, what type): _____
- Have you ever been on a **diet**? (If yes, what type): _____
  _____

Please list the typical foods you eat for:

Breakfast: _____
Snack
Lunch: _____
Snack
Dinner: _____
Snack

- Do you eat too much? __Rarely, __Occasionally,___Often
- Do you use salt on your food?_____
- Do you use sugar?_____
- Do you eat candy, cakes, pies, syrups? (If yes, how often):
- How often per week do you eat the following:
  Meats, fish, poultry, eggs: _____
  Milk, cheese, ice cream: _____
  Fats and oils: _____
  Vegetables & fruits _____
  Bread & cereals _____
- Do you use butter? margarine? _____
- Do you eat: French fries _____
  Potato chips _____
  Milk shakes _____
  Hamburgers _____
  Candy _____
  Sodas _____
- Do you drink cups of **milk**? What type? _____
- What do you think are the current factors contributing to your recent weight gain? _____
  _____
  _____

What is nutrition?

A. Nutrition is the process by which we eat food, digest, and assimilate it for use as energy to drive our bodies for growth, for tissue replacement, and health.

Nutritional Survey

Check only those you would answer yes….

__ I know what good nutrition is but it is difficult to apply
__ I must learn more about nutrition so I can eat better
__ I have specific problems
__ My nutrition is not good
__ I have been put on a restricted diet before

I have a history of:

- __ indigestion
- __ constipation
- __ diarrhea
- __ excess gas

__ I am overweight
__ I have trouble losing weight
__ I gain weight easily
__ I often have cravings for food I should not eat
__ I put salt on my food
__ I eat, chew, and swallow rapidly
__ I generally do not eat breakfast
__ I often eat while working on the run
__ I like to eat late at night…it helps me calm down
__ I do not usually read food labels

Too many checkmarks indicate your nutritional practices need revising.

PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

Stanley H. Title, MD PC Stacy F. Title, MD Craig I. Title, MD

200 West 57th Street NY NY 10019 142-10 Roosevelt Ave Flushing NY 11354

As required by the Privacy Regulations, I hereby acknowledge that I have read &/or received a current copy of Dr. Title's "NOTICE OF PRIVACY PRACTICES." I have been encouraged to read the Privacy Notice carefully prior to my signing this consent. I am aware the Privacy Notice is openly and publicly displayed in the office. Dr. Title and the Practice reserve the right to change its Privacy Practices that are described in its Privacy Notice, in accordance with applicable laws.

REQUESTS: Should I desire to file a Request for Restriction or Request for Alternative Communication or Objections to any aspect of the Notice of Privacy Practice, I will so note at the end of this Receipt of Notice.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

As required by the Privacy Regulations, Dr. Title may not use or disclose your protected health information except as noted below and as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use and/or disclose individually identifiable Patient Health Information about me for the use by or to the following persons, entities or agencies:

Insurance providers, Health Care Professionals, Emergency needs, Public Health & Safety, Research, Laboratory facilities, Organ Donation, Legal Entities as required by Law (eg. Public Health Authorities, Judicial & Administrative Proceedings, Law Enforcement),

I understand, and consent to, the following appointment reminders or communications that will be used by the Practice:

1. Appointment cards,
2. Phone calls to a phone number you designate or place of work regarding payments or appointments – upcoming or missed. Without leaving any health information, we may try to contact you by mail or phone to remind you about appointments, appointment changes, office schedules, etc., or if you are not available, we may leave a message on your answering machine or with the person answering the phone.
3. Sign in sheets in the front of our office,
4. Charts placed in the door of treatment rooms,
5. Fax transmissions to a fax number that you designate containing appointment reminders, laboratory results, or chart copies,
6. The calling aloud, via intercom, of your name in our waiting area to direct you to an examination or consultation room.

In the event that our office is sold or merged with another organization, your health information will become the property of the new owner. This Authorization will be effective from the date of your first visit to this office until such time of your written request(return receipt requested) that it expire. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

Stanley H. Title, MDPC has a Facebook and Twitter account for Advertising and Marketing purposes only, and does not intend to provide any medical advice on these sites. If you join our Facebook page or Twitter account to receive office marketing material, you do so voluntarily and understand that your Facebook or Twitter identity, and any information you provide on these sites, may be revealed or viewable by others also viewing these webpages or receiving this marketing material. As such, you are hereby notified that if you voluntarily join, others may identify you as a patient of this practice.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have read the Privacy Notice and understand my rights contained in the notice. All my questions have been answered to my full satisfaction prior to my signing below. By way of my signature, I provide Dr. Title and Practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described above and in the Privacy Notice.

Signature: X_____**X** **Print Name:** _____

(PATIENT or GUARDIAN - if under 18 years)

Witness: _____ **Date:** _____

Patient's Requests: _____

Name: _____

Updated: On	By	Computer Entry: On	By

Apt.#:_____

Address:

Phone: **cell:**

Office/Home:

Email: @

D.O.B. _____

I hereby grant permission to receive occasional **Postcards / direct mailings** from Dr. Title's office.

Patient Signature:_____

I hereby grant permission to receieve occasional **Email Newsletters** from Dr. Title's office.

Patient Signature: _____

☐ **Don't Mail** ☐ **Don't Email**

MEDICARE: **Y** ☐ **N** ☐

Opt Out On: _____

_____