

Steven Rosenzweig, M.D.  
Patient Registration Form

Registration form page 1

Today's date	
Patient name	Date of Birth
Address	
Best phone contact number: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	Alternative contact number: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work

**PRIVACY**

WE FOLLOW STANDARD PRIVACY PRACTICES. DID YOU WANT TO RECEIVE A WRITTEN COPY TO READ?

- No thanks: I don't need to receive or review a copy of the Notice of Privacy Practices  
 I have received and reviewed a copy of the Notice of Privacy Practices

WE NEED YOUR PERMISSION TO USE EMAIL

- I give permission for my email address to be used for appointment scheduling and reminders.  
 I give permission for Dr. Rosenzweig and his staff to correspond with me by email about my health information.  
Every effort is made to protect the confidentiality of all email correspondence. Email is a convenience but is optional.

**Email address:**

WE NEED YOUR PERMISSION FOR DR. ROSENZWEIG TO ACCESS YOUR ELECTRONIC MEDICAL RECORDS

- Yes, I give Dr. Rosenzweig permission to access available records.

WE NEED YOUR PERMISSION FOR DR. ROSENZWEIG TO DISCLOSE HEALTH INFORMATION TO YOU'RE YOUR HEALTH INSURANCE:

- Yes, I give permission to bill my insurance company and send a report back to my referring physician.

WE NEED YOUR PERMISSION FOR DR. ROSENZWEIG TO SEND HIS NOTES TO YOUR OTHER TREATING PHYSICIANS AND THERAPISTS:

- Yes, I give permission for Dr. Rosenzweig to send a report to any of my physicians or therapists.  
 No, Dr. Rosenzweig should only send my information to the following physicians or therapists (please list):

IF THERE ARE FAMILY MEMBERS OR OTHERS WITH WHOM YOU PERMIT DR. ROSENZWEIG TO DISCLOSE YOUR MEDICAL INFORMATION LIST THEM HERE:

X\_\_\_\_\_

Signature of Patient or Authorized Health Representative

Date

Patient name: \_\_\_\_\_

Registration form page 2

**INSURANCE INFORMATION**

**CO-PAYS:** Due at the time of your visit. Dr. Rosenzweig is listed as a specialist.  
Please call your insurance company ahead of time to determine your co-pay. We will not be able to do that for you.

**INSURANCE REFERRALS:** If your plan requires a referral form your PCP, please make sure we have that prior to your visit or we will have to reschedule.

Please provide us with a copy of your insurance cards or complete this section

**Primary Insurance Company:**

**Secondary Insurance Company:**

ID#                              Group #  
Name of policy holder  
Relation to patient

ID#                              Group #  
Name of policy holder  
Relation to patient

**FINANCIAL RESPONSIBILITY**

Name of Person Responsible for Payments:

Relationship to Patient:

Address and Phone Number (if different from above):

Patients are responsible for obtaining referrals if required by their insurance plan. This must be done by the time of the office visit. Otherwise we will need to bill you directly. Patients are responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service.

**Patients may be responsible for additional charges not covered by insurance:**

- Charge for missed appointments without 1 complete business day advance notice: \$150 for missed initial visit; \$75 for missed follow-up visit.
- Charge for returned checks
- Charge to established patients for telemedicine or telephone consultations not covered by your insurance plan – these are billed after the first 10 minutes at a prorated, hourly rate
- Charge for the copying and distribution of patient medical records
- Laboratory and other testing – Patients are responsible for verifying their own insurance coverage for any testing ordered by Dr. Rosenzweig.

**AUTHORIZATION AND RELEASE**

I authorize release of any information concerning my (this patient's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise provided to me directly to Dr. Rosenzweig for his services

X Signature of Patient or Guardian:

Date:

NAME PRINTED:

Steven Rosenzweig, M.D.  
Medical History Intake Form

<b>Visit Date:</b>	
<b>Patient Name:</b>	<b>Date of Birth:</b>
<b>Preferred Pronouns:</b>	
How would you prefer to be addressed by Dr. Steve?	
<b>Reason for Consultation:</b> Please list the major issue(s) here.	
<b>Referred by:</b>	
<b>Healthcare Team:</b> Who is the main physician in charge of your treatment (PCP or specialist)?	
Other key physicians / healthcare providers who treat you:	
<b>PART 1—MEDICAL HISTORY</b>	
<b>Please attach or send a written summary of your medical history or fill it in here:</b>	
<u>Past Medical History.</u> Attach list of all medical conditions, diagnoses, or medical problems for which you have been treated or list them here.	
<u>Major Surgeries:</u> Please list all major surgeries with dates.	
<u>Major Physical Injuries:</u> Please list with dates.	
<b>Allergies:</b>	
<u>Medication(s)</u>	<u>Nature of reaction:</u> _____
<u>Other (food, environmental, etc)</u>	<u>Nature of reaction</u>

Patient name: \_\_\_\_\_

**COVID19 Vaccination Status:**

Which vaccine?                      How many doses?

**Medications:** Attach or send a complete list of ALL prescription and over the counter medicines with doses or list here.

**Supplements / Herbal Medicines / Homeopathics:** Attach or send a complete list with doses or list here:

**Advance Care Planning – Living Will and Substitute Decision-Maker:**

Have you appointed a substitute decision-maker in the event that you can't make your own medical decisions even temporarily? This is also called having a healthcare proxy or giving someone medical power of attorney.

Name of substitute decision-maker:

Do you have a living will?

Do you need more information about this?

**Family Medical History:** Medical problems of your family members (including cancer, early heart disease, high blood pressure, diabetes)?

Father:

Mother:

Siblings:

Children:

Other family members with cancer, genetic diseases or other significant diagnoses:

Patient name: \_\_\_\_\_

## PART 2—SOCIAL HISTORY

Skip any questions you prefer not to answer

### Substance use:

Tobacco: Present use? Past use (number years)?

Are you in recovery?

Have you ever felt you ought to cut down on your drinking or drug use?

Have people annoyed you by criticizing your drinking or drug use?

Have you felt bad or guilty about your drinking or drug use?

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

### Social Support:

Is home wholesome and safe? With whom do you live?

Do you have a good social support or family, friends or neighbors?

In the past 12 months, did you worry that your food would run out or did it run out?

### Wellness Practices:

What is your diet like:

Exercise – type, intensity and frequency:

Mind-body-spirit practices (meditation, yoga, Tai Qi, prayer, etc.):

Alternative or complementary practitioners or therapies:

**Biographical:** Tell something about your daily routine, social role, interests, background:

**Spiritual or philosophical orientation:** Please share something about what gives your life meaning or a sense of connection to something greater.

**What else** would it be helpful for Dr. Rosenzweig to know about you?

Patient name: \_\_\_\_\_

**PART 3—SYMPTOM REVIEW**

<b>Symptom Checklist #1.</b> Please rate symptom intensity in general over the past week. <b>0</b> means no symptoms at all and <b>10</b> means worst imaginable.	
Pain.....0-1-2-3-4-5-6-7-8-9-10	Shortness of breath....0-1-2-3-4-5-6-7-8-9-10
Fatigue/tiredness...0-1-2-3-4-5-6-7-8-9-10	Anxiety/restlessness...0-1-2-3-4-5-6-7-8-9-10
Drowsiness.....0-1-2-3-4-5-6-7-8-9-10	Depressed / sad.....0-1-2-3-4-5-6-7-8-9-10
Nausea.....0-1-2-3-4-5-6-7-8-9-10	<i>Overall <u>diminished</u> sense of wellbeing.....0-1-2-3-4-5-6-7-8-9-10</i>
Loss of appetite ....0-1-2-3-4-5-6-7-8-9-10	

<b>Symptom Checklist #2.</b> Please indicate <b>CURRENT</b> or <b>RECENT</b> symptoms only:	
<b>General</b> <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Sleep problems <input type="checkbox"/> Sweats <input type="checkbox"/> Fatigue	
<b>Eyes</b>	<input type="checkbox"/> Dryness <input type="checkbox"/> Vision change
<b>ENT</b>	<input type="checkbox"/> Hearing change <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Sinus problems
<b>Heart/Circ</b>	<input type="checkbox"/> Chest pain with exertion <input type="checkbox"/> Elevated blood pressures on home monitoring <input type="checkbox"/> Irregular heart beat
<b>Breathing</b>	<input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Pain with breathing
<b>GI</b>	<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive gas <input type="checkbox"/> Blood or abnormal color of bowel movement
<b>Urological</b>	<input type="checkbox"/> Pain with urination <input type="checkbox"/> Abnormal frequency of urination
<b>Muscle/Joint</b>	<input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint swelling
<b>Neurologic</b>	<input type="checkbox"/> Faintness or dizziness <input type="checkbox"/> Headaches (not just mild & occasional) <input type="checkbox"/> Balance problems <input type="checkbox"/> Memory problems <input type="checkbox"/> Concentration problems
<b>Endocrine</b>	<input type="checkbox"/> Excessive thirst <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hair thinning
<b>Blood</b>	<input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Abnormal bruising
<b>Skin</b>	<input type="checkbox"/> Rash <input type="checkbox"/> Sores <input type="checkbox"/> Abnormal bumps
<b>Immune</b>	<input type="checkbox"/> Hives <input type="checkbox"/> Swollen glands <input type="checkbox"/> HIV positive status

**FEEDBACK:**  
How could we have made this form or registration process better or more comfortable for you?

*Almost done!*  
*Please complete the next pages giving permission for Dr. Rosenzweig to share information with your healthcare team*  
*Thank you!*

RELEASE #1: This form gives permission for records to be sent **TO:** Dr. Rosenzweig

<b>Patient's Name:</b>	<b>Date of Birth:</b>
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I authorize the following practice(s) to disclose my health information as described below to

**Steven Rosenzweig, MD**  
 123 Chestnut Street; Philadelphia, PA 19106  
 Fax: 888-802-0516; Tel: 215-627-3782

We are NOT requesting:  
 Psychotherapy notes  
 Drug and alcohol treatment reports

I am giving permission to include (should this apply to me):  
 Information about HIV diagnosis and treatment  
 Information about genetic testing results

NAME OF PHYSICIAN, INDIVIDUAL OR ENTITY	TYPE AND AMOUNT OF INFORMATION
	Recent and future progress notes and test reports

I understand that if I give permission, I have the right to change my mind and revoke it in writing. I also understand that any disclosures already made with my permission cannot be taken back. By signing this Authorization, I understand that any disclosure of information carries the potential for an unauthorized re-disclosure not protected by Federal privacy rules.

<b>SIGNATURE OF PATIENT OR AUTHORIZED HEALTH REPRESENTATIVE</b>	<b>DATE</b>
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<b>Authorized Health Representative's Name</b>	<b>Relation to Patient</b>
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RELEASE #2: This form gives permission for Dr. Rosenzweig to send his visit notes and test results TO your other healthcare providers.

**Patient's Name:**

**Date of Birth:**

I authorize Dr. Rosenzweig to share my medical information with my other healthcare providers.

NAME OF PHYSICIAN, INDIVIDUAL OR ENTITY	TYPE AND AMOUNT OF INFORMATION
	Recent and future progress notes

I understand that if I give permission, I have the right to change my mind and revoke it in writing. I also understand that any disclosures already made with my permission cannot be taken back. By signing this Authorization, I understand that any disclosure of information carries the potential for an unauthorized re-disclosure not protected by Federal privacy rules.

**SIGNATURE OF PATIENT OR AUTHORIZED HEALTH REPRESENTATIVE**

**DATE**

**Authorized Health Representative's Name**

**Relation to Patient**