N.Y.I.R
New York Integrated Rheumatology

PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME	DATE OF BIRTH	AGE	TODAY'S DATE
HOME ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE NO.	CELL PHONE NO.	WORK PHONE NO.	
SOCIAL SECURITY NO.	SEX	MARITAL STATUS	
EMAIL		DRIVER LICENSE NO.	
OCCUPATION	EMPLOYER NAME	EMPLOYER'S PHONE NO.	
REFERRING PHYSICIAN'S NAME		OFFICE PHONE NO.	
PRIMARY CARE PHYSICIAN		OFFICE PHONE NO.	
IN CASE OF EMERGENCY CONTACT PERSON, RELATIONSHIP		PHONE NO.	
Pharmacy Name & Telephone			

INSURED INFORMATION **If same as patient information mark here ( )**

NAME (LAST, FIRST, INIT)		DRIVER LICENSE NO.	
SOCIAL SECURITY NO.	DATE OF BIRTH	SEX (M/F)	
HOME ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER		RELATIONSHIP TO PATIENT	

INSURANCE INFORMATION

INSURANCE NAME	EFFECTIVE DATE
ID or SUBSCRIBER NO.	GROUP NO.
COPAY	Do you need a referral?

DO YOU SMOKE? _____ ANY MEDICATIONS, FOOD OR ENVIROMENTAL ALLERGIES? _____

PREFERRED METHOD OF COMUNICATION: CELL PHONE_____HOME PHONE_____EMAIL_____

WOULD YOU LIKE TO RECEIVE MOBILE TEXT NOTIFICATIONS TO REMIND YOU OF APPOINTMENTS?_____

PREFERRED LANGUAGE_____ ETHNICITY- NON HISPANIC_____HISPANIC_____

Long Island
4200 Sunrise Highway, Massapcqua, NY 11758
Tel: 516-809-9666 Fax: 516-809-9665

Manhattan
49 E. 78th Street, Ste 1B, New York, NY 10028
Tel: 212-288-3280 Fax: 877-769-7892

www.NYIR.com

Describe briefly your present symptoms: _____

_____

Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment for this problem:

_____

_____

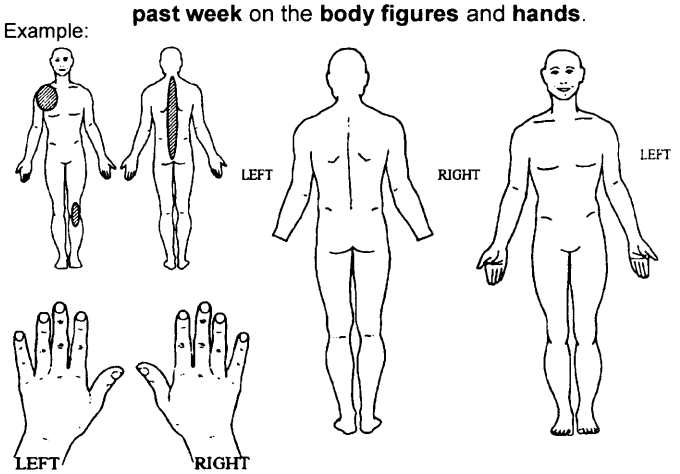
_____

Please list the names of other practitioners you have seen for this problem:

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.



Allergies

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Type of reaction: _____

Severity of reaction: Very Mild_____ Mild_____ Moderate_____ Severe_____

Present Medications

(List any medications you are taking, along with the dose. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Systems Review

As you review the following list, please check any of the problems, which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x–ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ❑ Recent weight gain
  amount _____
- ❑ Recent weight loss
  amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears–Nose–Mouth–Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began:_____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____/

Date of last pap?____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Social History

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago?_____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No
If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week_____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

Past Medical History

_____

_____

_____

_____

_____

_____

_____

_____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe:_____

Any other serious injuries? ❑ No ❑ Yes Describe:_____

Family History

Please indicate which specific family member(s) have or had any of the following conditions.

Cancer_____

Leukemia_____

Stroke_____

Colitis_____

Bleeding tendency_____

Alcoholism_____

Heart disease_____

High blood pressure_____

Rheumatic Fever_____

Epilepsy_____

Asthma_____

Psoriasis_____

Tuberculosis_____

Diabetes_____

Goiter_____

Financial Policy

New York Integrative Rheumatology & Arthritis Care is dedicated to providing you the most efficient care and service possible. Your understanding of our financial policy is an essential element of your care and service. If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our staff.
Full payment is due at the time of service. If you have insurance, and have signed an "Assignment of Benefits" statement, we will bill your insurance carrier for you if we are a provider on your plan. Balances are due within thirty (30) days of the billing statement date. This will only be excepted if you have made arrangements with the billing department prior to you visit. **Any balance unpaid after ninety days will be turned over to a collection agency*.**

It is your responsibility to know the details of your particular insurance policy. **Not all services are covered by all carriers.** Services which are not covered by your insurance are your responsibility. Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in order to obtain coverage by insurance. If your insurance has a **co-payment** policy, the co-payment is due at the time of service. If you have a **deductible**, you are responsible for all charges until the deductible is met. You are responsible for any and all allowable charges which remain after your insurance has paid its portion.
If your insurance carrier has a **"network"** of providers, it is your responsibility to make sure that we are an "in network" provider prior to obtaining services. If we are not "in network," we will still be happy to provide services; however, the percentage of charges for which you are responsible will be greater. It is also your responsibility to make us aware of any restrictions your policy has on ancillary services (such as requiring a specific lab).

It is your responsibility to make sure we have accurate insurance carrier information and billing information. If a claim is unsuccessful because of flawed insurance or billing information, you will be responsible for the balance.

We will make every effort to assist you in understanding the above information. We will also assist with any problems arising with your insurance to the extent we can accommodate.

I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment expected at the times services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

*In the event that my account becomes delinquent for more than 90 days, I also agree to pay all reasonable collection costs not to exceed 50%, court costs, attorney fees and interest fees accrued with the collection of this account.

_____ _____
Responsible Party Date

Appointment Policy

We will work hard to accommodate appointments that fit your schedule and medical needs. We ask that you let us know about cancellations or changes twenty-four hours in advance. Habitual missed appointments are grounds for dismissal from the practice. **Additionally our office will charge $25.00 for appointments that you do not keep and for appointments that you do not cancel twenty-four hours in advance.**

_____ _____
Signature Date

How did you hear of **New York Integrative**? _____

_____

ACKNOWLEDGEMENT FORM

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

I do____ do not____ authorize electronic communication between this office and me.

PATIENT NAME

(PRINT) _____

(SIGNATURE) _____

DATE: _____

WITNESS: _____

N.Y.I.R New York Integrated Rheumatology

Consent for Allopathic/Naturopathic Medicine

I, _____
(Please print full name)

Give consent to be treated by Dr. Waseem Mir at **New York Integrated Rheumatology**. I also acknowledge and declare that I have the option of seeking/continuing Allopathic (conventional) medical care. Since Dr. Mir practices both Allopathic and alternative medicine, it is solely my decision as a patient to choose treatment by either Allopathic medicine, Naturopathic medicine, or both

I confirm that there has been no suggestion made to me by **New York Integrated Rheumatology,** or by anyone under its direction or control, that I refrain from seeking or following Allopathic Medical treatment. I realize that I may seek/continue all other treatments if I desire. It is my responsibility to follow up with specific directions given by the doctor including follow ups, quantity intakes, and timely refills.

I have also read and understand the fee schedule that was given to me and understand that "*The substances prescribed by the Doctor at this office may be purchased from us, a pharmacy, a health store, or a medical supply company of my choice*."

Therefore, I hereby give my consent to assessment and treatment by Dr. Waseem Mir at **New York Integrated Rheumatology** as of this visit and further. If I have any questions or concerns I know to contact the doctor.

- Signature: _____
- Date: _____
- Doctor: _____
- Witness: _____

Waseem Mir. M.D.
Doctor of Rheumatology & Arthritis
Certified Acupuncturist NYIR.com

LONG ISLAND
4200 Sunrise Highway Massapequa, NY 11758
Telephone: 516.809.9666 Fax: 516.809.9665

MANHATTAN
49 East 78th Street, Suite 1B, New York, NY 10075
Telephone: 212.288.3280 Fax: 212.288.3280