



River Hospital *Serving the Thousand Islands Region*

4 Fuller Street • Alexandria Bay • New York • 13607

315-482-2511 telephone

315-482-4981 facsimile

River Community Clinic

Patient Information

NAME: _____

Last Name

First Name

Middle Initial

Soc. Sec. #: _____ Home Phone: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M F Date of Birth: _____ Please Circle: *Single Married Widowed Separated Divorced*

Patient's Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

In case of emergency who should be notified? _____

Guarantor Information

Person responsible for account: _____

Last Name

First Name

Middle Initial

Relation to Patient: _____ Birth: _____ Date: Soc. Sec. #: _____

Address (if different from patient): _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____ Business Phone: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Contract #: _____ Contract #: _____

Group #: _____ Group #: _____

Subscriber Name: _____ Subscriber Name: _____

ID#: _____ Date of Birth: _____ ID#: _____ Date of Birth: _____

River Community Clinic
Adult Medical History

Name: _____ Date of Birth: _____ Today's Date: _____

Briefly state the reason for today's visit: _____

Please list any medical problems for which you are currently under treatment: _____

Any medical problems in the past: _____

Any surgeries in the past: _____

Please list all previous hospitalizations: _____

List any medications or over the counter products taken on a regular basis: _____

Medication: _____ Dosage: _____ How many times a day: _____

Marital Status: _____ Number of children: _____ Do you smoke? Y N How much? _____

Do you have any problem with habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter your behavior? _____

Do you drink alcoholic beverages? Y N How often? _____ How much? _____

Do you do any regular exercise? Y N How often? _____ What type?: _____

Occupation: _____

Are you allergic to any medications? Y N If yes, please list with reactions: _____

Are you allergic to anything else? Y N If yes, please list with reactions: _____

Date of last tetanus shot: _____ Have you had the pneumonia vaccine? _____

Family history — if deceased, please list age and cause of death:

Father: _____ Mother: _____

Brother: _____ Sister: _____

Have any of your family members had the following: (If so, briefly explain.)

High blood pressure: _____ Heart attack: _____

Stroke: _____ Diabetes: _____

Cancer: _____ Kidney disease: _____

Blood disorders: _____ Other: _____

Please list any health concerns or questions you would like to discuss with our staff:

River Community Clinic
Adult Medical History (continued)

Do you currently have, or have you ever had, problems with any of the following:

Please **circle** all boxes that apply and **give a short description**.

- Headaches: _____
- Vision/hearing: _____
- Blood pressure: _____
- Chest pain: _____
- Heart disease: _____
- Asthma: _____
- Emphysema: _____
- Chronic cough: _____
- Indigestion: _____
- Ulcers: _____
- Nausea/vomiting: _____
- Abdominal pain: _____
- Gallbladder: _____
- Liver disease: _____
- Diarrhea: _____
- Constipation: _____
- Kidney Disease: _____
- Urination: _____
- Depression: _____
- Anxiety: _____
- Stress: _____
- Seizures: _____
- Gout: _____
- Arthritis: _____
- Skin rashes: _____
- Weight gain or loss: _____
- Thyroid: _____
- Insomnia: _____
- Cholesterol: _____
- Menstrual periods: _____
- Pregnancies: _____
- Cancer: _____

River Community Clinic
PATIENT CONSENT RECORD

Patient Name: _____ Date of Birth: _____

Consent for Treatments

I authorize River Hospital/Clinic to perform any and all medical and diagnostic treatments ordered by my physician. I authorize supervised students to observe and participate in my care.

Reason if not signed by patient _____

Witness to Signature

Signature of Patient/HCP/Nearest Relative

Date

Relationship to Patient

Authorization for Release of Information

I authorize River Hospital/Clinic to release any and all information related to my hospitalization and medical care to my insurance carrier, family physician, government agencies, or others responsible for my medical care.

Medicare Certification

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers and information for this claim. I request that payment of authorized benefits be made on my behalf.

Assignment of Benefits/Payment Guarantee

I assign and instruct my insurance company(ies) to pay River Hospital directly for hospital or clinic services. I understand that I am financially responsible for charges not made by this assignment, including collection costs. I will notify my insurance company of my admission if such notification is required.

Receipt of Information

I have received the Patient's Bill of rights, information relative to Advance Directives and New York Health Care Proxy information. I have had an opportunity to ask any questions I may have had pertaining to these materials.

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have been provided information regarding River Hospital/Clinic's Notice of Privacy Practices.

Witness to Signature

Signature of Patient/HCP/Nearest Relative

Date

Relationship to Patient

River Community Clinic

CONSENT TO DISCLOSE YOUR MEDICAL INFORMATION

Patient name: _____ Date of Birth: _____

To enable river Community Clinic to disclose information regarding your medical care, treatment plan, or test results with family or friends, please list below the individual(s) to whom you give permission to obtain your medical information from us.

Name: _____

Address: _____

Phone: _____ Relationship: _____

Name: _____

Address: _____

Phone: _____ Relationship: _____

Any person(s) you wish to RESTRICT from obtaining information, list below.

Name: _____

Patient signature: _____

Witness: _____



RIVER COMMUNITY CLINIC *Serving the Thousand Island Region*

*6 Fuller Street
Alexandria Bay, NY 13607
Phone 315-482-2094
Fax 315- 482-3727*

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: _____ DOB: _____ SSN: _____

Today's Date: _____ Authorization Expires: 90 days from today

To: (Name & Address of Doctor or Institution): _____

I hereby authorize the release/obtaining of my general protected health information to/from River Community Clinic, 6 Fuller Street, Alexandria Bay, NY 13607.

Information to be released /obtained: Check all that apply and enter date of service:

_____ Complete health record _____ ER Record _____ Consultation Reports
_____ History & Physical _____ Laboratory Tests _____ EKGs
_____ Operative Report _____ X-Ray Reports _____ Other _____

*Information not to be released: _____

The purpose of this request:

_____ Continuity of Patient Care _____ Compensation/Disability _____ Personal Records
_____ Insurance/Payment of Bills _____ Legal _____ School

Other (please specify) _____

I understand that I may revoke this authorization at any time by notifying the River Hospital in writing, but if I do it will not have any effect on any actions taken before they received the revocation. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. I understand that I may see a copy of the information described on this form and that I will get a copy of this form after I sign it if I ask for it. I understand that in compliance with New York statute, copies of records for personal use will be charged at \$.75 a page. Copies for continuity of care will be sent directly to the physician or health care facility at no charge.

This protected health information is intended only for the use of the individual or entity to which it is addressed and may contain information which is privileged, confidential and exempt from re-disclosure under applicable law. It is understood that River Hospital is released from all legal responsibility which may arise as a consequence of honoring this request.

Your signature on this form must be witnessed by another person of legal age. Please do not sign this form unless a witness is present.

Signature of Patient or Individual authorized to sign on Patient's behalf.

Date

Relationship to Patient

Witness Signature

Witness Printed Name

River Community Clinic

LATEX ALLERGY

Have you ever developed any type of reaction after handling latex products such as rubber gloves, condoms, diaphragms, balloons, or socks/underwear? NO YES

Comment: _____

Have you ever developed any type of reaction during or after a dental appointment, a vaginal/rectal exam, a surgical procedure, or with other exposure to rubber gloves? NO YES

Comment: _____

LATEX RISK

Have you ever had any difficulty breathing or hives after eating or handling any fruits or vegetables such as kiwi, bananas, stone fruits or chestnuts? NO YES

Comment: _____

Do you have a previous personal medical history of more than nine surgeries, spinabifida or repeated catheterizations? NO YES

Comment: _____

Are you frequently exposed to latex products in your occupation? NO YES

Comment: _____

Signature of Patient or Employee

Date

Assessment/Comments: _____
