Elmwood Village Primary Care
Frederick Michael Elliott, MD

897 Delaware Avenue, Suite 205
Buffalo, NY 14209

phone 716-768-2006 fax 716-768-2007
email info@elmwoodvillageprimarycare.com
online elmwoodvillageprimarycare.com

New Patient Registration Packet

Welcome to Elmwood Village Primary Care. If you are interested in joining our new medical practice, please review our online office policies first and then download and complete this New Patient Registration Packet. This Packet contain the following documents:

1. New Patient Registration Form.
2. New Patient Medical History Form.
3. Medical Records Release Form.
4. Patient Consent Form.

Please submit the Packet by mail or fax prior to your appointment if possible. After your New Patient Registration Packet has been received by our office, please call to schedule your new patient appointment. At your first office visit at Elmwood Village Primary Care please bring the following:

1. Your driver's license.
2. Your insurance card.
3. Your previous medical records if not already sent to our office.
4. Your copayment. The office currently accepts cash or check and will be accepting credit card payments as of May 15, 2013.

Please feel free to contact me at any time if you have any further questions.

Sincerely,

Frederick Michael Elliott, MD

Elmwood Village Primary Care

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1. New Patient Registration Form - Please Print

Personal Information		
Last Name	First Name	MI
Person responsible for payment (if not the patient,please include address/phone)		
Address		
City State Zip		
Home Phone	Cell Phone	Work Phone
When we need to contact you, which number is preferred? ❒ Home ❒ Cell ❒ Work ❒ No Preference May we leave confidential health information at this number? ❒ Yes ❒ No		

Date of Birth	Gender	Marital Status	Partner/Spouse's Name
Employer/School (if student)			Patient Email
Preferred Language	Non-English language needs? ❒ Yes ❒ No		Parent's Name if Minor
Preferred Pharmacy - please specify name & location			**How did you hear about us?**

Emergency Contact		
First & Last Name	Relationship to Patient	Best Number to Contact

Insurance Information		
	Primary Insurance	**Secondary Insurance**
Insurance Name: Through Employer? ❒ Yes ❒ No		
Product or Plan Name:		
Subscriber/Member ID:		
Group ID:		
Subscriber's Name (if not Patient) : Same address as above? ❒ Yes ❒ No		
Subscriber's Birthdate (if not the patient):		
Patient's Relationship to Subscriber: dependent, spouse, self, other:		
Effective Date and/or Renewal Date:		

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2. New Patient Medical History Form

Date: ______________________________

Last Name: ______________________ First Name: ____________________ M.I. ________

Nickname(s): ______________________ Birthdate: ____________________ Gender ______

Please complete this form as thoroughly as possible to aid in your diagnosis and treatment. This is a confidential record and will not be released, unless you have provided us with written authorization to do so.

Health Concerns

List your most important health concerns in order of significance.	Prior diagnosis of this problem? What was the diagnosis?
1.	
2.	
3.	
4.	
5.	

What goals do you have for your visit at the office today? ______________________________

____

Do you have any questions about our office? ______________________________

____

Please list prescription medications that you are currently taking (with dosages): ______________

____

____

Please list over-the-counter medications that you are currently taking (with dosages): ______________

____

____

Please list all supplements (vitamins, minerals, etc.) that you are currently taking (with dosages):

____

Please list any allergies to medications:

Personal Habits:

Please circle any of the following substances that you use regularly:

Tobacco Alcohol Coffee/Tea/Soda Recreational Drugs

Do you follow any particular exercise regimen or restrictions? If yes, please describe: ______

Do you exercise regularly? Yes No What type? ______

How long? ______ How often? ______

What are the stresses in your life? ______

Past History:

Hospitalizations: ______

Serious illnesses and/or injuries: ______

Date of last physical/annual exam: ______ Date of last blood tests: ______

Personal and Family History:

Please check the "YES" box next to each condition that applies to you or one of your family members. Please note whether the condition is in the past or current by marking "P" for past, or "C" for current. Indicate who had the condition in the "RELATION" column.

	YES	RELATION	RESOLVED(P)/(C)		YES	RELATION	RESOLVED(P)/(C)
Alcoholism/ Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History:

Please circle those that apply: Single Married Significant Other Divorced/Separated

Do you have children? Yes No Please list their age(s): ______

ELMWOOD VILLAGE PRIMARY CARE

3. Consent for Release of Medical Information

I hereby authorize the office/hospital of:

Office/Hospital name: ____

Address: ____
(Street) (City) (State) (ZIP)

or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of:

Patient name: ____

Address: ____
(Street) (City) (State) (ZIP)

Date of birth: __________________________ Medical record #: ______________________________

Date(s) of treatment: ____

To release information to: Elmwood Village Primary Care

Address: 897 Delaware Avenue, Suite 205 Buffalo, NY 14209
Phone 716-768-2006 Fax 716-768-2007 Email info@elmwoodvillageprimarycare.com

Initial all that apply:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ General hospitalization or outpatient care

_____ Drug and alcohol treatment care

_____ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

_____ Emergency room visit

_____ Psychiatric care

*requires special consent

I am requesting the following information to be released:

_____ Abstract of record (includes: history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)

_____ Entire medical record

_____ Other: _____Labs _____Slides** _____X-rays**

**I am aware that there are separate fees for and consents for X-rays, slides, and medical records, etc.

I permit this confidential information to be released for the following purpose:

_____ Continuing medical treatment _____ Litigation for review

_____ Insurance (company name): ____

_____ Other (specify reason): ____

This consent permits the Practice to use and disclose my health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

____ (Print patient's name)

____ (Signature of patient) Date: ____________

____ (Signature of legally authorized person)

If there are questions, please call Elmwood Village Primary Care at 716-768-2006.

Elmwood Village Primary Care

4. Patient Consent Form

Consent for Treatment

- ❒ I hereby authorize Dr. Frederick Michael Elliott, M.D. to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose, and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test, or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment. No guarantees have been made regarding the results of my evaluation and/or treatment. I understand I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating healthcare providers.

Privacy Notices

- ❒ I have reviewed and understand the Notice of Privacy Policies which is available on the medical office website.

Payment Policies

- ❒ Responsibility of Payment: I have received a copy of Elmwood Village Primary Care's payment policies and understand that if I am utilizing insurance it is my responsibility to understand my insurance benefits. I acknowledge that insurance coverage is not a guarantee of payment for services provided by my healthcare provider including preventive, routine screening, vaccinations, or procedures considered cosmetic in nature. I am financially responsible for all charges whether or not covered by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. It is my responsibility to pay any deductable amount, coinsurance, or any other balance not paid for by my insurance. I understand that co-payments are mandated by my insurance and are due at the time of service. It is my responsibility to notify the office upon arrival that a copayment is due and the amount due. Should I have no insurance or prefer that insurance not be billed, I understand that payment is due in full at the time of service.

- ❒ Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Elmwood Village Primary Care for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

- ❒ Returned Checks: I have been informed that returned checks are subject to a $35.00 handling fee for each submission. I have been informed that payment is due upon the receipt of my monthly statement. I understand that EVPC reserves the right to send past due accounts to collections and discharge me from service due to lack of payment.

Patient Name (please print) ____

Signature of Patient or Responsible Party ______________________ **Date** ____________