COLUMBIA UNIVERSITY
College of Physicians and Surgeons

ColumbiaDoctors of the Hudson Valley
Division of Cardiovascular Disease
222 Route 59
Suite 302
Suffern, NY 10901
845-368-0100 Telephone
845-368-3866 Facsimile

Dear Patient:

Our Practice is in the process of merging your chart into the ColumbiaDoctors electronic medical records system. Electronic medical records will help our physicians better serve you while providing mutual access amongst the physicians within ColumbiaDoctors.

Please bring the following forms filled out to your next visit and we will scan this into your electronic medical record. Your most current records will be scanned into the computer and moving forward all of your medical information will be entered and accessed electronically.

At ColumbiaDoctors of the Hudson Valley, your care is our main priority and we appreciate your business.

Thank you,

ColumbiaDoctors of the Hudson Valley

ColumbiaDoctors of the Hudson Valley

PATIENT DEMOGRAPHIC INFORMATION

OFFICE USE ONLY MD MRN

LAST NAME *MI (INITIAL)* *FIRST NAME*

❑ Female ❑ Male ❑ Single ❑ Married ❑ Divorced ❑ Widowed

AGE *SEX* *DATE OF BIRTH* *MARITAL STATUS*

STREET ADDRESS

APT. # *CITY* *STATE* *ZIP*

HOME PHONE *ALTERNATE PHONE*

EMAIL ADDRESS

MOTHER'S FIRST NAME *FATHER'S FIRST NAME*

EMPLOYER *BUSINESS PHONE NUMBER*

EMPLOYER'S ADDRESS

EMERGENCY CONTACT

Name	Relationship to Patient
Address	
Home Phone ( )	Work Phone ( )

PRIMARY CARE PHYSICIAN

Physician's Name	Phone Number
Address	

REFERRING DOCTOR'S INFORMATION

Physician's Name	Phone Number
Address	

INSURANCE INFORMATION

PRIMARY INSURANCE Primary Insurance Name	Phone
Address	
Identification Number	Group Number
Subscriber (if different from patient)	
Relationship to Patient	Date of Birth
SECONDARY INSURANCE Secondary Insurance Name	Phone
Address	
Identification Number	Group Number
Subscriber (if different from patient)	
Relationship to Patient	Date of Birth

I authorize my insurance benefits to be paid directly to ColumbiaDoctors of the Hudson Valley/Division of Cardiovascular Disease. I authorize ColumbiaDoctors of the Hudson Valley/Division of Cardiovascular Disease to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

PATIENT'S SIGNATURE *DATE*

ColumbiaDoctors of the Hudson Valley

FEDERAL GOVERNMENT REQUIRED QUESTIONS

The Federal Government requires us to ask these questions. This information is used to track illnesses by age, gender, race and ethnicity. We will also use this information to identify the needs of different patient groups and develop plans to address them and monitor the quality of our services for all patients so everyone gets the highest quality care regardless of their racial or ethnic background. We ask that you check one box under each category and thank you for taking the time to complete this information.

Name: _____ Date of Birth: _____

MRN#: _____ Visit Date: _____

ETHNICITY

- ❑ Decline Response (I do not wish to answer)
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

RACE

- ❑ Decline Response (I do not wish to answer)
- ❑ American-Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Other

PREFERRED LANGUAGE

- ❑ Decline Response (I do not wish to answer)

❑ ARABIC	❑ ITALIAN	❑ SPANISH
❑ CHINESE	❑ JAPANESE	❑ SWAHILI
❑ CZECH	❑ KOREAN	❑ TAGALOG
❑ DUTCH	❑ MALAY	❑ THAI
❑ ENGLISH	❑ PERSIAN	❑ TURKISH
❑ FRENCH	❑ POLISH	❑ URDU
❑ GERMAN	❑ PORTUGUESE	❑ VIETNAMESE
❑ GREEK	❑ ROMANIAN	❑ YIDDISH
❑ HEBREW	❑ RUSSIAN	❑ OTHER
❑ HINDI	❑ SIGN LANGUAGE	
❑ INDONESIAN	❑ SLOVAK	

STAFF: Please enter information on IDX and shred document. Do not scan into CROWN.

ColumbiaDoctors of the Hudson Valley

PATIENT QUESTIONNAIRE

NAME:_____ **DOB:**_____ **DATE:**_____

Who referred you to our office, and why?

List current medications, including over-the-counter preparations, you have taken recently.
Please indicate how many mg per dose and how many doses per day.

Drug allergies ❑ Yes ❑ No *If yes, explain*

Any medical conditions/illnesses? ❑ Yes ❑ No *If yes, explain*

Any surgeries, hospitalizations? ❑ Yes ❑ No *If yes, explain*

Any recent x-rays or other tests? ❑ Yes ❑ No *If yes, explain*

Do you have a history of these conditions? *(please check)*

- ❑ Hypertension
- ❑ Diabetes
- ❑ High Cholesterol
- ❑ Heart Attack
- ❑ Congestive Heart Failure
- ❑ Peripheral Vascular Disease
- ❑ Stroke or Mini-Stroke
- ❑ Coronary Artery Disease

Pharmacy name and phone number

Do you smoke? ❑ Yes ❑ No *If yes, how much*

Did you ever smoke? ❑ Yes ❑ No *If yes, for how long*

Do you drink alcohol? ❑ Yes ❑ No *If yes, how much*

Do you use recreational drugs? ❑ Yes ❑ No *If yes, list*

Do you exercise? ❑ Yes ❑ No *If yes, how much*

Does anyone in your family have any of the following?
If so, specify which family member *(e.g., mother, sibling, children, etc.)*

Yes	No		Yes	No	
❑	❑	Heart Disease _____	❑	❑	Stroke _____
❑	❑	High Blood Pressure _____	❑	❑	Dementia _____
❑	❑	Diabetes _____	❑	❑	Muscle Disorder _____
❑	❑	Cancer _____	❑	❑	Sensory Disorder _____
❑	❑	What organ _____	❑	❑	Incoordination _____
❑	❑	Arthritis _____	❑	❑	Shaking _____
❑	❑	Bleeding Disorder _____	❑	❑	Seizures _____
❑	❑	Kidney Disease _____	❑	❑	Headaches _____
❑	❑	Thyroid Disease _____	❑	❑	Mental Illness _____
❑	❑	Brain Tumors _____	❑	❑	Attention Deficit/Hyperactivity
❑	❑	Aneurysm _____			_____

Date of last menses
Could you be pregnant? ❑ Yes ❑ No

Age of Mother & Father *(if deceased, state cause)*

Are you right handed or left? ❑ Right ❑ Left

Height | Weight

Comments

Have you recently experienced any of the following? *(Please use the bottom of this page to elaborate when pertinent)*

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Fever	❑	❑	Chest Pain	❑	❑	Bone Problems	❑	❑	Difficulty Sleeping	❑	❑	Dizziness/Vertigo
❑	❑	Weight Loss/Gain	❑	❑	Palpitations	❑	❑	Neck/Lower Back Pain	❑	❑	Anxiety	❑	❑	Clumsiness
❑	❑	Change in Appetite	❑	❑	Shortness of Breath	❑	❑	Shooting Pain/Sciatica	❑	❑	Depression	❑	❑	Unsteadiness
❑	❑	Visual Change	❑	❑	Allergies	❑	❑	Muscle Pain	❑	❑	Headaches	❑	❑	Weakness
❑	❑	Hearing Loss	❑	❑	Constipation	❑	❑	Skin Problem	❑	❑	Change in Mental Acuity	❑	❑	Numbness/Tingling
❑	❑	Earache	❑	❑	Diarrhea	❑	❑	Bleeding or Bruising	❑	❑	Memory Problems	❑	❑	Stiffness/Slowness
❑	❑	Ringing in Ears	❑	❑	Abdominal Pain	❑	❑	Anemia	❑	❑	Hallucinations	❑	❑	Shaking
❑	❑	Cough	❑	❑	Black or Tarry Stools	❑	❑	Fatigue	❑	❑	Agitation/Confusion	❑	❑	Other
❑	❑	Sore Throat	❑	❑	Blood in Stools	❑	❑	Sleeplessness/ Sedation	❑	❑	Personality Changes			_____
❑	❑	Change in Smell	❑	❑	Problems Urinating				❑	❑	Difficulty Speaking			_____
❑	❑	Difficulty Swallowing	❑	❑	Sexual Problems				❑	❑	Change in Taste			_____
❑	❑	Nausea or Vomiting	❑	❑	Joint Pain									_____

REVIEWED BY _____ *DATE* _____

ColumbiaDoctors of the Hudson Valley

RELEASE OF INFORMATION

MRN_____

Patient's Last Name _____

Patient's First Name _____

Date of Birth_____

Address _____

_____

Home Phone_____ Alternative Phone _____

I hereby authorize you to transfer or make available to:
(Please list your primary care physician, any other physicians and/or family members who can access your records)

_____ _____

_____ _____

_____ _____

_____ _____

Relationship to patient: ❑ Spouse ❑ Child ❑ Other _____

Copies of the records and/or reports checked below relating to the above named patient's medical treatment:

❑ Records and Reports from _____ to _____

❑ All Records and Reports

❑ Other (specify)_____

I acknowledge that I have been provided with a copy of ColumbiaDoctors' Notice of Privacy Practices and have been given an opportunity to read and ask questions about the notice.

PATIENT SIGNATURE _____ *DATE*_____

ColumbiaDoctors of the Hudson Valley

PHARMACY INFORMATION

MRN _____

Patient's Last Name _____

Patient's First Name _____

Date of Birth _____

PRIMARY PHARMACY

Pharmacy Name	
Phone Number ( )	Fax Number ( )
Address	

SECONDARY PHARMACY

Pharmacy Name	
Phone Number ( )	Fax Number ( )
Address	

MAIL ORDER

Carrier	
Phone Number ( )	Fax Number ( )
Address	

COLUMBIA UNIVERSITY
MEDICAL CENTER

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA Compliance/Columbia University Medical Center
601 West 168th Street, Apt. #22, 2nd Floor
New York, NY 10032/ T(212) 342-0059 F(212)342-5173
http://www.cumc.columbia.edu/hipaa/

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:_____

I acknowledge that I was provided with a copy of the Columbia University Medical Center Notice of Privacy Practices.

_____ _____
Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____
Personal Representative (Print) Personal Representative's Signature

_____
Relationship

For Columbia University Medical Center use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center's Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other _____

_____ _____
Employee Name Date

This form should be placed in the patient's medical record