Robert G. Zingale, M.D., F.A.C.S., P.L.L.C.

158 East Main Street, Suite 7 • Huntington, NY 11743
Phone: 631-271-1822 • Fax: 631-271-1868

REGISTRATION FORM

Instructions: Fill in the blanks. Please replace any incorrect or outdated information

Patient Information

Patient Name	Gender	DOB	SSN	Race	ETHNICITY	PREFERRED LANGUAGE

Address	City, State, Zip	Marital Status

Home Phone	Home Fax #	Cell Phone	Email Address
( )	( )	( )	

Employer Name	Employer Address	City, State, Zip	Work Phone
			( )

WORKER'S COMP INJURY	Date of Injury	Last Date Worked	NO-FAULT INJURY	Date of Injury
☐ Yes ☐ No			☐ Yes ☐ No	

Emergency Contact

Contact Name	Home Phone	Work Phone
	( )	( )

Guarantor Name	Relationship	Home Phone	Work Phone
		( )	( )

Other Name	Relationship	Home Phone	Work Phone
		( )	( )

Physician Information

Referring Physician's Name	City, State, Zip	Phone
		( )

Primary Care Physician Name	City, State, Zip	Phone
		( )

Insurance Information

PRIMARY Insurance Name	Certificate / Policy #	Group #	Phone
			( )

Address	City, State, Zip

Insured's Name	Relation to Insured	Insured's DOB	Effective Date	Expiration Date

SECONDARY Insurance Name	Certificate / Policy #	Group #	Phone
			( )

Address	City, State, Zip

Insured's Name	Relation to Insured	Insured's DOB	Effective Date	Expiration Date

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct Dr. Robert Zingale, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to Dr. Robert Zingale, sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan. (Medicare) I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration and HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim I request that payment of authorized benefits payable be made on my behalf. I assign the benefits for physician services to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment to me.

_____ _____

Signature of Patient or Authorized Guardian DATE

AUTHORIZATION TO RELEASE INFORMATION VIA E-MAIL

By providing your e-mail address you agree to receive by e-mail address information about your healthcare, including protected health information.

_____ _____

Signature of Patient or Authorized Guardian DATE

(Please print)

Name:_____ **Date of Birth:**_____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ African-American ☐ More Than One Race
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Caucasian ☐ Refused to Report/Unreported

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report/Unreported

Language: ☐ English ☐ Spanish ☐ Other:_____

Pharmacy: _____
(Name/City/Phone #)

Do you use a mail order pharmacy?_____ If so, please be sure we have your pharmacy provider information and a copy of your prescription drug card.

Mail Order Pharmacy: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

Timing/Onset:
When did symptoms first occur? _____

Is this due to an accident? _____

Duration:
Frequency of symptoms? _____

Characterized as/Severity:
Describe the severity of the symptoms/pain. _____

Associated Signs and Symptoms:
Are there any other symptoms associated with your problem? _____

Modifying Factors:
What makes the condition better and/or worse? _____

Have you been treated for this condition by any other provider? If yes, please name. _____

Diagnostic Imaging:

Have you had previous diagnostic imaging done (i.e. MRI, x-ray, CT Scan, EMG)? If so, when and where:_____

_____

Problem List/Past Medical History:

Have you been diagnosed with any of the following (currently or in the past)?

- ☐ Alcoholism
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ GERD (Reflux Disease)
- ☐ Gout
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Thyroid Disorder
- ☐ Wound Infection

List any other important medical condition(s) you have had (do not include common colds of flu).
Include date of initial diagnosis if possible:

Problem/Previous Diagnosis *Date(s) or Age*

PAST SURGICAL HISTORY:

☐ I have not had any surgeries in the past.
Place an "X" next to any past surgical procedure you have had, and circle Left (L) or Right (R) if applicable:

			Date(s) or Age	Surgeon
☐ Gall Bladder Surgery				
☐ Colon Surgery	☐ L	☐ R		
☐ Bowel Surgery				
☐ Groin Hernia Surgery	☐ L	☐ R		
☐ Abdominal Wall Hernia Surgery				
☐ Appendectomy				
☐ Mastectomy	☐ L	☐ R		
☐ Hysterectomy				
☐ Cesarean Section				
☐ Heart Surgery				
☐ Prostatectomy				
☐ Diskectomy				
☐ Spinal Fusion				
☐ Arthroscopic Surgery	☐ L	☐ R		
☐ Total Knee Replacement	☐ L	☐ R		
☐ Total Hip Replacement	☐ L	☐ R		
☐ Total Shoulder Replacement	☐ L	☐ R		

Other (Surgery(s), Date/Age, & Surgeon)_____

ALLERGY HISTORY:

☐ None ☐ NKDA (No Known Drug Allergies)

☐ Anesthesia ☐ Iodine ☐ Penicillin ☐ Sulfa Drugs ☐ Adhesive Tape
☐ Contrast Dye ☐ Latex ☐ Shellfish ☐ Other:_____

MEDICATION HISTORY:

☐ I am not currently taking any medications.
List any medications, vitamins, minerals and herbals that you are currently taking or provide us with a list:

Name of Medication	Dosage	Name of Medication	Dosage

FAMILY HISTORY

Has any member of your family been diagnosed with any of the following conditions (include deceased family members? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer: (Type _____)	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
HIV Infection	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐

List any other important family medical condition(s) you are aware of (do not include common colds of flu). Include date of initial diagnosis if possible:

Family Member *Medical Condition / Date of Initial Diagnosis*

_____

_____

_____

_____

_____

_____

Have you or anyone in your family (mother, father, sister, brother) ever had a reaction to anesthetic, general or local, causing high fever (malignant hyperthermia), blood pressure problems, hepatitis or any other type of allergic reaction?

Yes ☐ No ☐ If yes, please explain: _____

SOCIAL HISTORY

What is your current occupation? _____

Please describe your current tobacco use: ☐ Never a smoker ☐ Former Smoker ☐ Current every day smoker ☐ Current some a day smoker ☐ Current status unknown ☐ Unknown if ever smoked

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☐ Yes ☐ No

If yes, please indicate what type of drug and how often: _____

Please describe your current exercise routine: ☐ Inactive ☐ Light ☐ Moderate ☐ Vigorous

If you do have a current exercise routine, how many times per week: _____

Height:_____ **Weight:**_____ **Age:**_____

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

☐ I have none of these symptoms.

General:
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Other

Skin:
- ☐ Rash
- ☐ New Lesions
- ☐ Other

HEENT:
- ☐ Headache
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Hearing Loss
- ☐ Other

Neck:
- ☐ Neck Mass
- ☐ Swollen Glands
- ☐ Other

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty Breathing
- ☐ Other

Cardiovascular:
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Palpitations
- ☐ Other

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Other

Genitourinary:
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence
- ☐ Other

Musculoskeletal:
- ☐ Muscle Weakness
- ☐ Muscle Atrophy
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Joint Pain
- ☐ Other

Neurological:
- ☐ Tingling
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke
- ☐ Other

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Easily Irritated
- ☐ Other

Endocrine/Glands:
- ☐ Thyroid Problems
- ☐ Other

Hematology:
- ☐ Anemia
- ☐ Blood Clots
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Other

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PATIENT'S NAME:	DOB:	DATE:

Please list all your treating physicians:

PHYSICIAN'S NAME:	PHYSICIAN'S SPECIALTY:
ADDRESS:	ZIP:
TELEPHONE #:	FAX #:

PHYSICIAN'S NAME:	PHYSICIAN'S SPECIALTY:
ADDRESS:	ZIP:
TELEPHONE #:	FAX #:

PHYSICIAN'S NAME:	PHYSICIAN'S SPECIALTY:
ADDRESS:	ZIP:
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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the **Notice of Privacy Practices** for the office of Dr. Robert G. Zingale. Should I have any questions about the policy, I will discuss them with my physician or the office staff.

Print Name:_____

Signature:_____

Date:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO:

Print Name:_____**Relationship**_____**Phone:**_____

Print Name:_____**Relationship**_____**Phone:**_____

Print Name:_____**Relationship**_____**Phone:**_____

Print Name:_____**Relationship**_____**Phone:**_____

May we leave medical information on your home or work answering machine and/or cell phone?_____

Patient Signature:_____ **Print Name/Date:** _____