The Elliot Lewis Center

Ellen Lathi, MD
Joshua Katz, MD
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110 Cedar Street, Suite 110
Wellesley, MA 02481

Name: _____
Last First MI

Date of Birth: _____ / _____ / _____ **Social Security#:** _____

ADDRESS Street: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: _____ **Secondary Phone:** _____

Email: _____

Primary Care Physician: _____ **Phone:** _____

Address: _____

PRIMARY INSURANCE

Name: _____

Policy / ID: _____

Group #: _____

SECONDARY INSURANCE

Name: _____

Policy/ ID: _____

Group #: _____

Emergency Contact: _____ **Relationship:** _____

Primary Phone: _____ **Secondary Phone:** _____

Medical Information and Payment Authorization

I request that payment of authorized medical benefits be made on my behalf to _____
For services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or other insurer, any information to determine these benefits payable for related services.

Signature: _____ **Date:** _____

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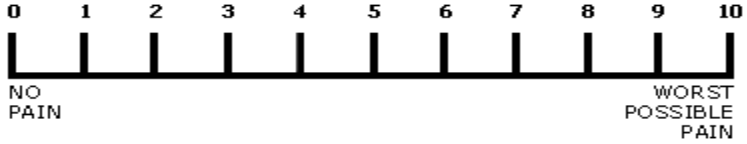
PATIENT QUESTIONNAIRE

Name:	*Date: / /*

GENERAL	**Y**	**N**	***EXPLAIN BELOW***		**Y**	**N**	***EXPLAIN BELOW***
Skin Problems/Rash				**GI**			
Anemia				Nausea/Vomiting			
Fever/Chills				Diarrhea/Constipation			
Night Sweats				Bloody or black stool			
EYES/EARS				Heart Burn			
Visual Changes				Weight Loss/Gain			
Hearing Changes				Abdominal Pain			
NOSE/THROAT				**NEUROLOGIC**			
Hoarseness				Convulsions/Seizures			
Trouble Swallowing				Headache			
Gland Swelling				Dizziness/Passing Out			
RESPIRATORY				Shaking/Tremors			
Cough				Muscle Weakness/Fatigue			
Shortness of Breath				Tingling/Numbness			
Wheezing				Loss of Feeling			
Sputum Production				Back Pain			
UROLOGIC				**MOOD/SLEEP**			
Pain/Frequent Urination				Nervousness/Anxiety			
Blood in Urine				Depression			
Trouble Urinating				Sleep Disorder/Fatigue			
Urinary Incontinence				**PSYCH-COGINTION**			
CARDIOVASCULAR				Hallucinations			
Chest Pain				Paranoid Feelings			
Leg/Back pain walking				Memory Loss			
Ankle Swelling							
Fast Heart Beat/Murmur							

Please rate your pain on the following scale:



Do you smoke now or did you ever smoke? Yes No
If yes, how many packs a day?
For how long?
When did you quit?

Do you drink alcohol? Yes No
If yes, how may drinks per week?

Do you or did you every have a problem with alcohol or drug use?

Do you have an Advanced Care Plan? Yes No

What medications are you currently taking? (Prescription, OTC, Herbals, Vitamins, Supplements)

Medications	**Dose**	**Frequency**	**Route Taken (by mouth, injection)**

Please circle any anti-inflammatory medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

Advil Arthrotec Daypro Ibuprofen Lodine Naprelan Naproxen

Oruvail Tylenol Ultram Other:
_____

Please circle any of the following side effects while you were currently taking any of the above anti-inflammatory medications.

Nausea Diarrhea Gastric Ulcers Upset stomach Vomiting

Other:
_____

Are you currently taking any of the following on a regular basis?

Aspirin Axid Coumadin Cytotec Heparin Maalox Mylanta

Pepcid Prevacid Prilosec Tagamet Zantac

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Notice of Privacy Rights & Practices

This notice explains how medical information may be used and disclosed and how you may have access to this information. Please review carefully.

Examples of how we can use and disclose your information without your authorization include:

Treatment: the office keeps records of each visit, including test results, diagnoses, and medications. These records are used and disclosed to allow doctors, nurses and health care staff to provide high quality care to meet your needs.

Payment: the office may use and disclose information related to services you receive at your visits, so we can be paid by you, your insurance company, and/or a third party. We may disclose an upcoming treatment or service to your health plan for prior authorization or approval.

Health Care Operations: the office uses and discloses your medical information to improve services and train staff.

Additional Uses and Disclosures
There are additional times when we are required or permitted to use or disclose medical information without your permission:

- Emergency treatment situations
- Reporting abuse or neglect
- Workers compensation
- To avert a serious threat to public or safety
- For public health activities
- For health oversight activities
- For research following an appropriate review or waiver of authorization
- For coroners, medical examiners and funeral directors
- For correctional institutions
- For government functions
- For law enforcement
- If required by law

I, _____ , have received a copy of The Elliot Lewis Center Notice of Privacy Practices.

_____

Signature Date