



**PATIENT MEDICAL HISTORY**  
PLEASE FILL IN ENTIRE PATIENT MEDICAL HISTORY FORM

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ Date of birth \_\_\_\_\_

IS YOUR GENERAL HEALTH: \_\_\_\_\_ EXCELLENT \_\_\_\_\_ GOOD \_\_\_\_\_ FAIR \_\_\_\_\_ POOR

WHAT IS YOUR HEIGHT \_\_\_\_\_ CURRENT WEIGHT \_\_\_\_\_

1. DO YOU HAVE ANY PAST OR PRESENT ILLNESS? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF SO, LIST: \_\_\_\_\_

2. HAVE YOU HAD ANY PREVIOUS SURGERIES? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF SO, LIST: \_\_\_\_\_

3. HAVE YOU OR YOUR FAMILY / RELATIVES HAD AN UNEXPLAINED  
OR SERIOUS COMPLICATION DURING SURGERY? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF SO PLEASE EXPLAIN: \_\_\_\_\_

4. PLEASE CHECK IF YOU HAD OR STILL HAVE ANY OF THE CONDITIONS

LISTED BELOW:

_____ ULCER, HIATUS HERNIA	_____ HEART MURMUR	_____ BACKPAIN
_____ BLOOD CLOT	_____ PALPITATIONS	_____ ARTHRITIS
_____ SWOLLEN LEGS	_____ PACEMAKER	_____ WEAKNESS
_____ BRONCHITIS	_____ CHEST PAIN, ANGINA	_____ EMPHYSEMA
_____ WALKING PROBLEMS	_____ KIDNEY PROBLEMS	_____ BLACKOUTS
_____ HEPATITIS A	_____ HEPATITIS B	_____ HEPATITIS C
_____ PNEUMONIA	_____ BRUISING	_____ BLEEDING
_____ LIVER PROBLEMS	_____ LUNG PROBLEMS	_____ ASTHMA
_____ RHEUMATIC FEVER	_____ EPILEPSY	_____ HEADACHES
_____ SHORTNESS OF BREATH	_____ SICKLE CELL ANEMIA	_____ GLAUCOMA
_____ MENINGITIS	_____ POLIO	
_____ THYROID DISEASE	_____ HIGH BLOOD PRESSURE	_____ BLINDNESS
_____ DEAFNESS	_____ DIABETES	_____ ANEMIA
_____ PREDNISONE TREATMENT	_____ CORTISONE TREAT	_____ HEART ATTACK
_____ PERSISTENT INDIGESTION	_____ NERVOUS DISORDER	
_____ EMOTIONAL DISORDER		

5. DO YOU TAKE ANY MEDICATION OR DRUGS? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF YES, LIST MEDICATIONS AND DOSAGE: \_\_\_\_\_

6. DO YOU HAVE ANY DRUG ALLERGIES? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF YES, PLEASE LIST \_\_\_\_\_

7. DO YOU HAVE ANY FOOD ALLERGIES? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF YES, PLEASE LIST \_\_\_\_\_

8. DO YOU SMOKE CIGARETTES / TOBACCO? \_\_\_\_\_ YES \_\_\_\_\_ NO

9. DO YOU TAKE ASPIRIN OR ASPIRIN PRODUCTS REGULARLY? \_\_\_\_\_ YES \_\_\_\_\_ NO

10. HAVE YOU EVER BEEN OR ARE CURRENTLY BEING TREATED FOR ANY  
PSYCHOLOGICAL OR PSYCHIATRIC DISORDERS \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, PLEASE LIST TREATING THERAPIST OR PHYSICIAN  
\_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_

Stafford R. Broumand, M.D.  
 740 Park Avenue  
 New York, NY 10021  
 Tel (212) 879-7900 Fax (212) 879-3387  
 E-Mail: [DrBroumand@aol.com](mailto:DrBroumand@aol.com)

**PATIENT RECORD OF DISCLOSURES**

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

<input type="checkbox"/>	Home Telephone _____	<input type="checkbox"/>	Written Communication
<input type="checkbox"/>	O.K. to leave a message with detailed information	<input type="checkbox"/>	O.K. to mail to my home address
<input type="checkbox"/>	Leave message with call-back number only	<input type="checkbox"/>	O.K. to mail to my work/office address
<input type="checkbox"/>	Work Telephone _____	<input type="checkbox"/>	O.K. to fax to this number _____
<input type="checkbox"/>	O.K. to leave message with detailed information	<input type="checkbox"/>	O.K. to send email to this address _____
<input type="checkbox"/>	Leave message with call-back number only	<input type="checkbox"/>	Other _____

X \_\_\_\_\_  
 Patient Signature

Date

X \_\_\_\_\_  
 Print Name

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

*Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.*

**Record of Disclosures of Protected Health Information**

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

Dated: New York, New York  
 \_\_\_\_\_, 200\_\_

X \_\_\_\_\_  
**SIGNATURE OF PATIENT OR REPRESENTATIVE**

X \_\_\_\_\_  
**PATIENT'S NAME PRINTED**

X \_\_\_\_\_  
**NAME OF PERSONAL REPRESENTATIVE**

X \_\_\_\_\_  
**RELATIONSHIP TO PATIENT**

STAFFORD R. BROUMAND, M.D.  
740 PARK AVENUE  
NEW YORK, NY 10021  
(212) 879-7900 \* FAX (212) 879-3387 \* EMAIL [DRBROUMAND@AOL.COM](mailto:DRBROUMAND@AOL.COM)

**INSURANCE PAYMENT AUTHORIZATION FORM**

DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

INSURANCE CARRIER \_\_\_\_\_ ID \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ GROUP \_\_\_\_\_

I AUTHORIZE DR. STAFFORD BROUMAND TO BILL MY INSURANCE CARRIER FOR SERVICES RENDERED TO ME. I AGREE TO FORWARD TO DR. BROUMAND ANY INSURANCE PAYMENTS THAT I MAY RECEIVE FOR SERVICES RENDERED TO ME BY DR. BROUMAND. I AM AWARE THAT I AM RESPONSIBLE FOR ALL CHARGES SUBMITTED TO MY INSURANCE CARRIER SHOULD THEY DENY PAYMENT FOR SERVICES RENDERED. I AM ALSO RESPONSIBLE FOR ANY PORTION OF MY BILL NOT ENTIRELY COVERED OR PAID BY MY INSURANCE CARRIER. I AM AWARE THAT IF I DO NOT SEND DR. BROUMAND THE FULL INSURANCE REIMBURSEMENT ONCE RECEIVED, MY ACCOUNT WILL BE SUBJEC TO AN INTEREST CHARGE. IF ASKED FOR A SURGERY DEPOSIT FEE, THE FEE WILL BE APPLIED TOWARD SURGERY CHARGES AND IS NOT CONSIDERED FULL PAYMENT FOR SURGERY.

PATIENT'S SIGNATURE: \_\_\_\_\_ PRINT: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ PRINT: \_\_\_\_\_

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I AUTHORIZE DR. BROUMAND TO SUBMIT INFORMATION TO MY INSURANCE CARRIER FOR CLAIM PROCESSING ON MY BEHALF. I AUTHORIZE DR. BROUMAND ON MY BEHALF TO APPEAL AND / OR REVIEW ANY CHARGES SUBMITTED TOMY INSURANCE SHOULD THEY DENY OR REQUEST ADDITIONAL INFORMATION.

PATIENT SIGNATURE: \_\_\_\_\_ PRINT: \_\_\_\_\_

INSURED: \_\_\_\_\_