NAME: _____

CHART: _____

DATE: _____

DARIUS KOHAN, M.D., P.C.
863 PARK AVENUE, SUITE 1E
NEW YORK, NY 10075
TELEPHONE (212) 472-1300 FAX (212) 472-1336

Select Name: _____ Date: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Email Address: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Marital Status: Select _____ Sex: Select _____

Occupation: _____ Employer: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Cell Phone: _____ Home Phone: _____

RECEIVED NOTICE OF PRIVACY PRACTICE: Sele

Primary Insurance:

Name of Insured: _____

Relationship: _____

Policy Number: _____

Employer: _____

Insurance Company: _____

Group Number: _____

Secondary Insurance:

Name of Insured: _____

Relationship: _____

Policy Number: _____

Employer: _____

Insurance Company: _____

Group Number: _____

Send Reports To:

Doctor: _____ Office Phone: _____

Address: _____

Referred By: _____ Phone: _____

Address: _____

Patient or Authorized Signature

This signature will act as a "SIGNATURE ON FILE" and will remain active for all claims.

Signature: _____ Date: _____

NAME: _____

CHART: _____

DATE: _____

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Past Medical History (check all that apply to you, not your family)

Diabetes	☐	Anemia	☐	High Blood Pressure	☐	Bleeding Disorder	☐
Stroke	☐	Cancer	☐	Heart Disease	☐	Liver Disease	☐
Tuberculosis	☐	Major Injuries	☐	Kidney Disease	☐	None of the Above	☐

Have you ever been hospitalized or had surgery? Yes ☐ No ☐ (if yes, list dates below)

_____

_____

_____

Are you taking any prescription or non-prescription medications? Yes ☐ No ☐ (if yes, please list below)

_____

_____

_____

Do you have allergies? Yes ☐ No ☐ Not Sure ☐

Please list any allergies to: Medications: _____
Foods: _____
Other: _____

Have you ever received allergy shots? Yes ☐ No ☐

Family History (check all that apply)

Heart Disease ☐ Bleeding Disorders ☐ Hearing Loss ☐ High Blood Pressure ☐

Social History (questions may not apply to children)

Have you ever smoked cigarettes? Yes ☐ No ☐ How much? _____ How long? _____

Do you currently smoke cigarettes? Yes ☐ No ☐

Do you use any other tobacco products? Yes ☐ No ☐ If yes, describe _____

Do you drink alcohol? Yes ☐ No ☐ How much? _____

Do you use any other drugs? Yes ☐ No ☐

What is your weight? _____ What is your height? _____

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Please check any conditions or symptoms you have experienced. If you have not experienced any, check NONE.

General:
Weight Loss/Gain ☐ Fever ☐ Night Sweats ☐ None ☐

Ear, Nose, Mouth, and Throat:
Dizziness ☐ Nasal Discharge ☐ Ear Drainage ☐ Hoarseness ☐ Hearing Difficulty ☐
Nose Bleeds ☐ Sinus Pain ☐ Imbalance ☐ Nasal Stuffiness ☐ Ear Pain ☐
Sore Throats ☐ Ringing in the Ear ☐ Vertigo ☐ Falling ☐ None ☐

Eyes:
Nearsightedness ☐ Farsightedness ☐ Glaucoma ☐ Itching ☐
Double Vision ☐ Blurry Vision ☐ Tearing ☐ None ☐

Respiratory:
Shortness of Breath ☐ Pneumonia ☐ Asthma ☐ Bronchitis ☐ Coughing ☐ None ☐

Gastrointestinal:
Difficulty Swallowing ☐ Heartburn ☐ Ulcers ☐ Constipation ☐ None ☐

Cardiovascular:
Chest Pain ☐ Palpitations ☐ Murmurs ☐ Pacemaker ☐ None ☐

Renal:
Urinary Retention ☐ Kidney Stones ☐ None ☐

Endocrine:
Cold Intolerance ☐ Heat Intolerance ☐ Pituitary Disease ☐ Menstrual Irregularity ☐
Thyroid Disease ☐ None ☐

Immunologic:
Immune Deficiency ☐ Allergies ☐ None ☐

Hematologic:
Anemia ☐ Swollen Lymph Nodes ☐ Easy Bruising or Bleeding ☐ None ☐

Neurologic:
Headaches ☐ Weakness ☐ Numbness ☐ Migraines ☐ Gait Disorder ☐ Speech Disorder ☐
None ☐

Psychiatric:
Depression ☐ Mania ☐ Anxiety ☐ Eating Disorder ☐ Schizophrenia ☐ None ☐

Musculoskeletal:
Arthritis ☐ Joint Swelling ☐ Neck Pain ☐ Back Pain ☐ None ☐

Skin:
Rashes ☐ Itching ☐ Moles ☐ None ☐

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Relationship To: _____

Patient's Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason: