ANGELA AZAR M.D. PC

LILIYA BESEDINA, M.D
RONIT SHABATIAN RPA-C
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935 NORTHERN BLVD SUITE 106 GREAT NECK NY 11021
92-11 ROOSEVELT AVE JACKSON HEIGHTS NY

Please Note: All information is confidential and will become part of your medical record**. Do not leave any boxes empty**, mark N/A for not applicable or none if appropriate. PLEASE PRINT CLEARLY

OFFICE USE ONLY
REVIEWED_____
ENTERED _____
SCANNED _____

New Patient Intake Form

Patient Information: **Today's Date: _____**

Last Name: _____ **First Name**: _____

Date of Birth: _____ **Sex (circle)** Male or Female

Phone Numbers: Home: _____ Cell: _____

May we leave a detailed message? **YES NO**

Email Address: _____

Do you give **Angela Azar M.D** permission to send email to this address? (Circle) **YES NO**

Home Address: _____ City: _____

State: _____ **Zip Code: _____**

Marital Status :(circle) Married Single Divorced Separated Widowed Other

Place of Birth: _____

Occupation: _____ **Employer**: _____

Name of Primary Insurance Company: _____

Who referred you to us? _____

PRIMARY CARE PHYSICIAN: COPIES OF REPORTS/RESULTS SHOULD BE SENT TO:

_____ _____
PHYSICIAN'S NAME **ADDRESS**

_____ _____
PHONE NUMBER **FAX NUMBER**

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Pharmacy Information: Name_____ Phone: _____

Address_____

City: _____ State: _____

EMERGENCY CONTACT:

Name: _____Relationship to patient_____

Phone: _____

***If you are a female, are you, or is there a chance you may be pregnant?** Yes or No

* Are you nursing? Yes or No * When was you last menstrual period? _____

*What **skin** issue will be discussed today? _____

PAST DEMATOLOGICAL HISTORY (Please Circle)

Melanoma …… **YES NO** Eczema ……. **YES NO**

Squamous cell skin cancer …….. **YES NO** Psoriasis …….**YES NO**

Basal cell skin cancer (Most common) …… **YES NO** Other: _____

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Past Medical History: **(PLEASE CIRCLE ALL THAT APPLY)**

ANXIETY	**DEPRESSSION**	**LEUKEMIA**
ARTHRITIS	**DIABETES**	**LUNG CANER**
ASTHMA	**END STAGE RENAL DISEASE**	**LYMPHOMA**
ATRIAL FIBRILLATION	**GERD**	**PROSTATE CANCER**
BONE MARROW	**HEARING LOSS**	**RADIATION TREATMENT**
TRANSPLANTATION	**HEPATITIS**	**SEIZURES**
BPH	**HIGH BLOOD PRESSURE**	**STROKE**
BREAST CANCER	**HIV/AIDS**	**PACEMAKER**
COLON CANCER	**HIGH CHOLESTEROL**	**CORONARY ARTERY DISEASE**
COPD	**THYROID PROBLEMS (HYPER OR HYPO)**	

NONE

Past Surgical History:

_____

Allergies: **(PLEASE CIRCLE)**

Anesthesia	**YES**	**NO**	Animal Dander	**YES**	**NO**
Latex	**YES**	**NO**	Dust	**YES**	**NO**
Shellfish	**YES**	**NO**	Pollen	**YES**	**NO**
Seafood	**YES**	**NO**	Ragweed	**YES**	**NO**

Other: _____

****Current Medications: (DO NOT LEAVE THIS BLANK)**

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Do you have any of the following? Please circle

Heart Failure? YES or No
Coronary Artery Disease? Yes or No
Chronic Obstructive Pulmonary Disease? Yes or No
Diabetes? Yes or No

2. Did you receive the flu vaccine before this past flu season? Yes or No

3. Have you ever received the Pneumonia vaccine?(Adults 65 years or older) Yes or No

4. Do you smoke? Yes or No

5. Healthcare Proxy (Lets you appoint another person to express your wishes and make healthcare decisions for you if you cannot speak for yourself)

Name:_____ Relationship to Patient:_____

Phone:_____

Social History: (Please Circle)

Do you use sunscreen?	**YES**	**NO**	
Do you tan?	**YES**	**NO**	**……If YES, how often? _____**
Do you smoke cigarettes	**YES**	**NO**	**…….If YES, how many packs per day? _____**
Do you consume alcohol	**YES**	**NO**	**… If YES, how much consumption per day? _____**

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Family History: Does a family member have any of the following?

	Who? (Mother, Brother, etc.)?
Melanoma	
Basal cell skin cancer	
Eczema	
Psoriasis	
Cholesterol	
Diabetes	
Hypertension	

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR INSURANCE PLAN'S POLICIES AND TO GET REFERRALS FROM YOUR PRIMARY CARE PHYSICIAN IF REQUIRED BY THE PATIENT'S INSURANCE PLAN. EVEN IF WE ARE IN NETWORK WITH YOUR INSURANCE, DEDUCTIBLES OR COINSURANCE MAY APPLY, WHICH MEANS YOU MAY BE RESPONSIBLE FOR A PORTION OF THE CHARGES.
PLEASE INITIAL HERE _____

Release of Information:

I agree that **Dr.Angela Azar MD PC** may disclose certain health information to a person(s) other than me because such person(s) is involved in my health care or payments related to my health. In that care, we will only disclose information that is directly relevant to the person's involvement in my health care or payments related to my health care. I designate the following persons for the limited purposed described above. I understand that I am not required to list anyone, and can change this list at any time in writing.

Name of person: _____ Relationship to patient _____