ANTHONY J. BARONE, M.D.
725 Reservoir Avenue, Suite 303
Cranston, Rhode Island 02910
401-944-6510

Welcome to our office
Please complete the following forms

Patient Name: ______________________ Date of Birth: ______________________

Parent's/Guardian's Name(s): ______________________ ______________________

Gender: Male ____ Female ____ Marital Status: S M W D

Occupation: ______________________ Employer: ______________________

Reason for your Visit: ____

Referring Physician: ______________________ Address: ______________________

Telephone: ______________________ City: ______________ State: _____ Zip: _____

Primary Care Physician: ______________________ Address: ______________________

Telephone: ______________________ City: ______________ State: _____ Zip: _____

INSURANCE INFORMATION:

Primary Insurance: ______________________ Secondary Insurance: ______________________

ID: ______________ Group: __________ ID: ______________ Group: __________

Policy Holder Name: ______________________ Policy Holder Name: ______________________

Date of Birth: _______ Relationship: __________ Date of Birth: _______ Relationship: __________

PHARMACY INFORMATION:

Pharmacy Name: ______________________ Address: ______________________
Telephone: ______________________ City: ______________ State: __________

All patient charges are due at the time of service.
Insurance Authorization and Assignment: I herby authorize Anthony J. Barone, M.D. to furnish information to my insurance carrier(s) concerning my illness and treatment. I hereby assign to the physician all payments for medical services rendered to my dependant or myself. I understand I am responsible for any amounts not covered by insurance. A copy of this signature is valid as the original. I give permission for the physician to treat my dependant or myself medically.

Signature: ______________________________ Date: ______________________

ANTHONY J. BARONE, M.D

PATIENT HEALTH FORM

Patient Name:______________________________ Date of Birth: ____________________

Address: ____________________________ City: _______________ State: ________ Zip Code: _________

Home Telephone: _________________ Cell Phone: _________________ Work: ___________________

In Case of Emergency – Name: ___________________ Relationship: _______________ Telephone: ______________

Email address: ____

MEDICAL HISTORY: *Please check off health conditions for which you are being treated or take medication for:*

__High Blood Pressure
__High Cholesterol
__Tuberculosis
__Stomach Ulcer
__Thyroid Problems
__Bleeding Problems
__Heart Disease
__Kidney Problems
__Heart Attack
__Vascular Problems
__Arthritis
__Liver Problems
__Osteoporosis
__Blood Clots
__Seizures/Epilepsy
__Psychiatric Problems
__Back/Neck Pain
__HIV/AIDS
__COPD/Emphysema
__Stroke
__Cancer
__Diabetes
__Asthma
__Anemia

MAJOR SURGERIES: *(Please list procedure and year)*

_____________________ _____________________ _____________________

_____________________ _____________________ _____________________

CURRENT MEDICATIONS: (*Please list all current medications – **include over the counter** - or provide a list for us to copy and attach)*
*If you do not take any medication, **please circle*** - **I TAKE NO MEDICATION**

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

ARE YOU ALLERGIC TO ANY MEDICATION(S): _________________________________ *if NONE, **please circle:*** **NKDA**

Do you smoke tobacco? Yes/No/Quit How many packs per day? _____For how many years: ______
Do you drink alcohol? Yes/No Frequency/Quantity: __________________________________

PLEASE CHECK ANY SYMPTOMS YOU *ARE EXPERIENCING AT THIS TIME*: *(Review of Systems)*

CONSTITUTIONAL: __Fever __Chills __Night Sweats __Sudden Weight Gain/Loss
NEUROLOGICAL: __Headache __Dizziness __Fainting
EYES: __Eye Pain __Vision Changes __Tearing/Itchy Eyes
ENT: __Hearing Loss __Ear Pain __Ear Discharge __Ringing in Ears __Nasal Congestion
__Runny Nose __Nasal Bleeding __Hoarseness __Difficulty Swallowing __Sore Throat
NECK: __Swollen Glands __Neck Mass/Lump
CARDIOVASCULAR: __Chest Pain __Palpitations
PULMONARY: __Cough __Wheeze __Shortness of Breath
GASTROINTESTINAL: __Abdominal Pain __Nausea __Vomiting
SKIN: __Rash __Unexplained Bruising
PSYCHIATRIC: __Intent to Harm Self

FAMILY HISTORY: **HAVE MEMBERS OF YOUR FAMILY EXPERIENCED ANY OF THE FOLLOWING?** *(Circle all that apply):*

Environmental Allergies Sinus Problems Chronic Headaches Head/Neck/Throat Cancer
Hearing Loss Sleep Apnea Vertigo/Dizziness Bleeding Problems

PATIENT SIGNATURE: ____ **DATE:** ____________________

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

I understand that, under the Health Insurance Portability & Accountability Act, 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 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 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 requested restriction, but if you agree then you are bound to abide by such restrictions.

Patient Name (Print)____________________________________
Signature: ____
Date:____
Relationship to Patient__________________________________

Collection of Deductible, Coinsurance, & Copayments.

I understand that I am responsible for paying my provider directly for any applicable deductible, coinsurance, & copayment. This is a mandatory requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier, and seek alternative methods of collection. Failure to meet my obligations is a violation of my agreement with my insurance carrier an the carrier may take additional action. I also understand that if I have longstanding unpaid deductibles, coinsurance, & copayments owed to my provider, my provider may terminate the Doctor (or healthcare practitioner) patient relationship as a result, subject to the requirements of state and or federal law. I further understand that if my provider collects any applicable deductible from me and is also reimbursed directly from my insurance carrier, that I will be reimbursed from my provider any overpayment owed to me.

Patient/ Guardian Signature:____
Date:____