Evia Medical Center

100 Terry Road
Smithtown, New York 11787
Phone: (631) 979-7400 Fax: (631) 979-7440
Internal Medicine, Integrative Medicine, Osteopathic Medicine, Acupuncture, Medical Massage
E. Lila Augoustiniatos, MD, FACP
Darla E.Lynch, MD, MS
Lawrence Salob, DO, FACOFP
Elizabeth Kollar, ANP-C

REGISTRATION FORM

(Please verify the information we have. Make any changes or additions needed. Print print.)

Today's Date: «Today» PCP: «ProviderName»

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr ❑ Mrs. ❑ Miss ❑ Ms.	Marital Status (Circle One)
«LastName» ,	«FirstName»	«MiddleName»		Single / Mar / Part/ Div / Sep / Wid

Is this your legal name?	If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex
❑ Yes ❑ No			«DOB»	«Patient.Age»	«Sex»

Street Address	City	State	ZIP Code	Cell Phone No.	Home Phone No.
«Street»	«City» , «State» «Zip»				( ) «PhoneNumber»

P.O. Box City State ZIP Code

Occupation	Employer	Employer Phone No.
«Patient.Occupation»	«Employer.OrgName»	( ) «Employer.Phone»

Patient E-mail address (Required): _____

INSURANCE INFORMATION (please give your insurance card to the receptionist)

Person Responsible for Bill	Birth Date	Address (if different)	Home Phone No.
«FullName»	«DOB»	«Street1» «City» , «State»	( ) «Phone»
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No.
	«Employer»		( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Medicare ❑ NYSHIP Empire Plan ❑ Anthem Empire BC/BS
❑ Oxford ❑ United Healthcare ❑ CIGNA ❑ Federal BC/BS ❑ Other «CompanyName»

Subscriber's Name	Birth Date	Group #	Policy #
«FullName»	«DOB»	«GroupName»	«PolicyID»

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other «Relation»

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Practice. I understand that I am financially responsible for any balance. I also authorize the release to my insurance company(ies) any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

** How did you find out about our office? _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)* ***«NameLastFirst»*** «Sex»	**DOB** «DOB»
Marital Status: Single Partnered Married Separated Divorced Widowed	
Previous or Referring Doctor:	**Date of Last Physical Exam:**

PERSONAL HEALTH HISTORY

Childhood Illness: Measles Mumps Rubella Chicken Pox Rheumatic Fever Polio

Immunizations and Dates:

Tetanus	Pneumonia
Hepatitis	Chicken Pox
MMR	Shingles
Influenza	COVID Vaccine(s)

List Medical Problems / Health Concerns:

Surgeries: ☐ **NONE**

Year	Reason	Hospital

Other Hospitalizations: ☐ **NONE**

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Continued on Next Page

List Current Medications, Hormones: ☐ **NONE**

Name of Drug	Strength	Frequency Taken

List over the counter vitamins/supplements ☐ **NONE**

1	3	5
2	4	6

Allergies to Medications: ☐ **NONE**

Drug Name	Reaction	Drug Name	Reaction

Food Allergies: ☐ **NONE**
☐ **Beef** ☐ **Cheese** ☐ **Chocolate** ☐ **Citrus** ☐ **Corn** ☐ **Eggs** ☐ **Milk** ☐ **Mold** ☐ **Peanuts** ☐ **Oat** ☐ **Pork**
☐ **Shellfish** ☐ **Wheat** ☐ **Other** _____

Environmental Allergies: ☐ **NONE**

HEALTH HABITS AND PERSONAL SAFETY

Exercise:
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Sleep Habits: Hrs of Sleep ___ Restful Sleep? ☐ Yes ☐ No Ever tested for Sleep Apnea? ☐ Yes ☐ No
Was sleep Apnea diagnosed? ☐ Yes ☐ No Do you follow a treatment plan? ☐ Yes ☐ No

Diet: Are you dieting? ☐Yes ☐No If yes, are you on a physician prescribed medical diet? ☐Yes ☐No
# of meals you eat in an average day? ____

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:
Do you drink alcohol? ☐ Yes ☐ No
If yes, what kind?_____ How many drinks per week? _____
Are you concerned about the amount you drink? ☐ Yes ☐ No
Have you considered stopping? ☐ Yes ☐ No
Have you ever experienced blackouts? ☐ Yes ☐ No
Are you prone to "binge" drinking? ☐ Yes ☐ No
Do you drive after drinking? ☐ Yes ☐ No

Tobacco:
Do you use tobacco? ☐ Yes ☐ No
If Yes: ☐ Cigs ☐ Pipe ☐ Cigars ☐ Vape Amt:_____ How long? ___ yrs. ☐ Quit:

Drugs:
Do you currently use recreational or street drugs? ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Continued on Next Page

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Sex: Are you sexually active? ☐ Yes ☐ No
If yes, are you trying for a pregnancy? ☐ Yes ☐ No
If not trying for a pregnancy, list contraceptive or barrier method used. _____
Any discomfort with intercourse? ☐ Yes ☐ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, continues to be a public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your doctor about your risk for this illness? _____ ☐ Yes ☐ No

Personal Safety: Do you live alone? ☐ Yes ☐ No
Do you have frequent falls? ☐ Yes ☐ No
Do you have vision or hearing loss? ☐ Yes ☐ No
Do you have an Advance Directive and/or Living Will? ☐ Yes ☐ No
Would you like information on the preparation of these important documents? ☐ Yes ☐ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? _____ ☐ Yes ☐ No

Please remember that the following recommendations are very important to maintaining your health.

When in a car, wear your safety belt at all times. While riding a motorcycle or bicycle, wear a helmet. Always have functional smoke detectors and fire extinguishers in your home. If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm. Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

		Age Now	At Death	Health Problems or Cause of Death
Father				
Mother				
Siblings	**M F**			
	M F			
	M F			
	M F			
	M F			
	M F			

		Age Now	At Death	Health Problems or Cause of Death
Children	**M F**			
	M F			
	M F			
	M F			
Grandparents (Mother's Side)				
Male				
Female				
Grandparents (Father's Side)				
Male				
Female				

Continued on Next Page

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes ☐ No
Do you feel depressed or cry frequently?	☐ Yes ☐ No
Do you panic when stressed?	☐ Yes ☐ No
Do you have problems with eating or your appetite?	☐ Yes ☐ No
Have you ever attempted suicide or thought about hurting yourself?	☐ Yes ☐ No
Do you have trouble sleeping?	☐ Yes ☐ No
Have you ever been to a counselor?	☐ Yes ☐ No

WOMEN ONLY

Age at onset of menstruation: Date of last menstruation:

Period every ____ days. Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes ☐ No
Number of pregnancies Number of live births	
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Have you had a D&C, hysterectomy, or Cesarean section?	☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or sweating at night?	☐ Yes ☐ No
Do you have menstrual tension, pain, irritability, or other symptoms at or around time of period?	☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes ☐ No

Date of last pap smear ___/___ mammogram ___/___ rectal exam ___/___
colonoscopy ___/___ bone density___/___

MEN ONLY

Do you usually get up to urinate during the night? ☐ Yes ☐ No If yes, # of times _____	
Do you feel pain or burning with urination?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Do you feel burning discharge from penis?	☐ Yes ☐ No
Has the force of your urination decreased?	☐ Yes ☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes ☐ No
Do you have any problems emptying your bladder completely?	☐ Yes ☐ No
Any difficulty with erection or ejaculation?	☐ Yes ☐ No
Any testicle pain or swelling?	☐ Yes ☐ No

Date of last prostate exam ___/___ rectal exam ___/___ colonoscopy ___/___

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Skin	Back	Energy Level
Head/Neck	Intestines	Ability to Sleep
Ears	Bladder	**Other Pain/Discomfort:**
Nose	Bowels	
Throat	Circulation	
Lungs	**Recent Changes In:**	
Chest/Heart	Weight	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

«Today»

SIGNATURE ALSO REQUIRED ON LAST PAGE!!!

«NameFirstLast» *please sign*

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E. Lila Augoustiniatos, MD, FACP
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Lawrence Salob, DO, FACOFP
Elizabeth Kollar, ANP-C

«Today»

«Patient Name»
«DOB»
«Email»
«Cell Phone Number»
«Home Phone Number»

Patient Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of This Notice: E. Lila Augoustiniatos, MD, PC d/b/a Evia Medical Center (THE PRACTICE) is required by law to maintain the privacy of your confidential medical record and to provide you with a notice of our legal duties and privacy practices with respect to your information. This Notice describes your legal rights, advises you of our privacy practices, and lets you know how they permitted to use and disclose this information.

Uses and Disclosures of PHI: THE PRACTICE may use your patient information for the purposes of treatment, payment, and other health care operations. The law permits them to use your confidential information for these areas without your consent. Examples are as follows:

Treatment: This includes verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including physicians who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of information via fax, telephone or other forms of communication to hospitals or other healthcare providers, as well as providing a copy of the written record we create in the course of providing you with treatment.

Payment: This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your information and submitting bills to insurance companies (either directly or via third party billing), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

Health Care Operations: This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care, obtaining financial and legal services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Reminders for Scheduled Appointments or Information on Other Services: We may contact you with a reminder about scheduled appointments , or for other information about other services we provide or other health related benefits or services that may be of interest to you.

Use and Disclosure of Information Without Your Consent: THE PRACTICE is authorized to use your medical record without your consent, authorization, or written permission in certain situations, including:

- **Emergencies:** if your medical condition is such that time is of the essence and attempting to obtain consent would present an obstruction to timely care, or if your condition is such that you are unable to effectively and competently give consent. In these situations we will attempt to get your written consent after the emergency.
- To a relative, friend or individual involved in your care
- To public health authorities in certain situations (reporting a birth, death, or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect, to report domestic violence, to report product defects, or to notify someone about exposure to infectious disease as required by law).
- For health oversight activities, such as audits, government investigations
- Response to judicial and legal proceedings, such as response to subpoena or other legal process, after reasonable attempts to notify you of the subpoena.
- For law enforcement activity in limited circumstances, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime
- For military, national defense and security
- To avert a serious threat to a person or the public at large
- For worker's compensation proceedings as required by law
- Any other use of your confidential patient record will require your signed consent in advance.

Patient Rights

As a patient, you have a number of rights:

The right to access, copy or to inspect your medical record: This means you may come to our offices during regular business hours and copy most of the information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may charge a reasonable fee for you to make such copies. We may deny you access to your information in some circumstances. Certain types of denials may be appealed. We have forms available to request access to your information, and will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical record, you should contact the privacy officer listed at the end of this notice.

The right to amend your medical record: You may ask us to amend written medical information we have about you. This would generally occur within 60 days of your request and will notify you when this occurs. We are permitted under the law to deny your request under certain circumstances, like when we believe the information you are asking us to amend is correct. This denial can be appealed. If you wish to amend the medical information we have about you, contact the privacy officer at the end of this notice.

The right to request an accounting of our use and disclosures of your medical record: You may request an accounting of our use and disclosure of your medical information we have made in the last six years prior to the date of your request. We are not required to provide uses and disclosures of your PHI for purposes of treatment, payment or health care operations, or uses and disclosures made prior to April 14, 2003. If you wish an accounting of your medical record, contact the privacy officer listed at the end of this notice.

The right to request restrictions on uses and disclosures of your medical record: You have the right to request restrictions on how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. However, if you request a restriction, and that information is needed to provide you with emergency care, then we may use the information or disclose the information to a health care provider to provide you with emergency treatment. THE PRACTICE is not required to agree to any restrictions you request, but any restrictions agreed to by THE PRACTICE is binding on them.

Legal Rights and Complaints: Notice of any changes in this privacy policy may be shown directly on the consent form and this Notice will be updated when any significant changes occur. THE PRACTICE reserves the right to change the terms of this notice at any time, and the changes will be effective immediately. We also reserve the right to make any changes effective for medical records that we have created or received prior to the effective date of the Notice provision that was changed.

You also have the right to complain to us or the Secretary of the Federal Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or the government. Should you have any questions, comments, or complaints you may direct all inquiries to the privacy officer, Ms. Cheryl Johnston, Evia Medical Center, 100 Terry Road, Smithtown, NY 11787.

I understand that I may refuse the to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Patient / Guardian Signature: _____Date: _____

Name:_____
«NameFirstLast»

AUTHORIZATION TO BILL YOUR INSURANCE

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf to Evia Medical Center/LIIFM for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient / Guardian Signature _____ Date:_____

Name:_____
«NameFirstLast»

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COMMUNICATION CONSENT FORM

«Today»

PATIENT NAME: «FirstName» «LastName»
DOB: «DOB»

I hereby authorize the doctors and staff of Evia Medical Center to contact me at the phone numbers indicated below:

Cell:	_____	May Leave Detailed Message on Voice Mail	☐ Yes ☐ No
Home:	_____	May Leave Detailed Message on Voice Mail	☐ Yes ☐ No
Work:	_____	May Leave Detailed Message on Voice Mail	☐ Yes ☐ No
Other:	_____	May Leave Detailed Message on Voice Mail	☐ Yes ☐ No

Please indicate below any individuals with whom the staff of Evia Medical Center may discuss any and all medical problems, tests and results (e.g. spouse, child, parent, other):

1._____

2._____

3. _____

We contact you via email for appointment reminders, general information, and billing statements.
We do not email Protected Health Information (PHI).

Please enter your email address here: *(required)

* email : _____

Patient/Guardian signature X_____

«NameFirstLast» «Today»