HIGHGATE
medical group

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Williamsville, NY 14221
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Suite 104 & 207

3950 E. Robinson Rd
W. Amherst, NY 14228
Phone: (716) 564-1111
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Physicians
Michael Dlugosz, M.D.
Stacey Gugino, M.D.
Justin Green, M.D.
Nicholas Pantano, M.D.
Lori Luzi, M.D.
David Pawlowski, M.D.
Michael Freitas, M.D.
Kristina Semidey, M.D.

Nurse Practitioners
Kathleen Barone, F.N.P.
Kimberly MacDonald, F.N.P.
Sharon Tasner, F.N.P.
Elliott Yadon, F.N.P.
Rachel Yadon, F.N.P.

Physician Assistants
Derek Aube-Marchant, PA-C
Jessica Schoenhals, PA-C
Brie Anne Slaughter, PA-C
Stephanie Guize, PA-C
Jillian LaMarca, PA-C
Christine Divita-McKenna, PA-C
Chelsey Milleville, PA-C
Alicia Reimondo, PA-C
Renee Sawka, PA-C
Megan Schifferli, PA-C
Chelsea Percy, PA-C
Emily Kowalski, PA-C
Meaghan Piegay, PA-C

Long-Term Nursing Care/Short-Term Rehab
Ellen Brody, F.N.P.
Danielle Casillo, A.G.N.P.
Leah Gorsline, PA-C
Kimberly Gruber, F.N.P.
Sandy Michel, A.N.P.
Erin Morgan, PA-C
Christina Parkot, F.N.P.
Elizabeth Leiser, F.N.P.
Mallory Furniss, F.N.P.
Mary Nolan, PA
Sara Baker, F.N.P.
Larika Evans, F.N.P.
Veronica Miles, F.N.P.
Chris Laduca, PA
Tiffany Phalen, PA
Timothy Giglio, ANP

Welcome, and thank you for considering Highgate Medical Group, P.C. for your health care needs. We are dedicated to providing you and your family the best in modern medical services in a caring environment. Our goal is to provide you with the highest quality of care and positive patient experience.

In order to expedite your patient registration, please bring the following to your appointment:

- Health Insurance Card
- Photo Identification
- Health Records – including immunizations
- Completed enclosed forms

We offer the following service to make your experience both easy and convenient:

Our phones are turned off and on service during the lunch hour 11:50-1PM daily

- Monday 7-6 PM
- Tuesday 7-6 PM
- Wednesday 7-6 PM
- Thursday 7-6 PM
- Friday 7-5 PM (Office Phones turn off at 4PM)
- Saturday 8AM – 1PM (At our Williamsville location for all patients)
  - Same day sick visits only

We offer the following service to make your experience both easy and convenient:

- Same Day appointment availability
- Our affiliation with McGuire Group gives us access to continue care with short-term rehabilitation and long-term nursing home care coverage
- An online patient portal, for easy communication and appointment scheduling. We anticipate all patients to use the patient portal to effortlessly retrieve test results and communicate directly with your care team.

Your primary care physician plays an important role in the coordination of your care. We have a provider on call 24 hours a day, 7 days a week to help with emergency situations. We can help you identify the most appropriate level of care and refer you to providers that share our philosophy of patient-centered medical care.

We look forward to meeting you!

Highgate Medical Group, P.C.

www.highgatemedical.com
You can also make payments on our website!

APPOINTMENT DATE: _____ **TIME:** _____

PROVIDER: _____

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PATIENT REGISTRATION

Patient Name: _____ **Date of birth:** _____

Mailing Address: _____

Home Phone Number: _____ **Cell Phone Number:** _____

Email: _____ **Cell Phone Carrier:** _____

Pharmacy Name & Address: _____

Marital Status: Single Married Divorced Widowed Legally Separated

Sex: Male Female Other **Ethnicity**: Hispanic/Latino Not Hispanic/Latino

Race: White/Caucasian Black/African American American Indian/Alaska Native
Asian Native Hawaiian or Other Pacific Islander

Primary Language: _____

Employment Status: Full Time Part Time Retired Self Employed Unemployed

Employer: _____ **Occupation:** _____

Insurance Name: _____ **ID #** _____

Subscriber Name: _____ **Relation:** _____

Secondary Insurance Name: _____ **ID #** _____

Subscriber Name: _____ **Relation:** _____

Emergency Contact Name: _____

Phone Number: _____ **Relation:** _____

Who referred you to Highgate Medical Group? Are any family members or friends currently under our care?

_____

_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or responsible party) Signature: _____ **Date:** _____

Patient Health History

Name: _____ **Date: _____**
SSN: _____ **DOB: _____**

Chief Complaint: What is the reason for your visit today? (Please describe the problem in detail):

_____
_____
_____

Patient Medical History: Please check all that apply to you

☐ Asthma/COPD	☐ Depression/Anxiety	☐ Hypertension	☐ Thyroid disease
☐ Autoimmune Disease	☐ Diabetes	☐ Kidney disease	☐ Other _____
☐ Arthritis	☐ Gastrointestinal disease	☐ Sleep apnea	☐ None
☐ Cancer	☐ Heart disease	☐ Stroke	

Please describe:

_____
_____
_____

Previous Surgeries: Please list any surgeries with approximate date

_____
_____

Serious Injury: Please describe any previous serious injuries (i.e. car accident, fractured bones)

_____
_____

Medications: Please list any medications including the dose and frequency. (there is additional space on the next page)

Drug	***Dose/Frequency***
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: please list any allergies that you have including reaction

_____
_____

Social History:

Do you drink alcohol?	☐ **YES** ☐ **NO**	If yes, how much/week? _____
Do you smoke?	☐ **YES** ☐ **NO**	If yes, how many cigarettes per day? _____
Do you consume caffeine?	☐ **YES** ☐ **NO**	If yes, how many cups per week? _____
Do you use recreation drugs?	☐ **YES** ☐ **NO**	If yes, what type/frequency? _____
Are you on a special diet?	☐ **YES** ☐ **NO**	If yes, please describe? _____

Family History: Do you know of any blood relative who has or had:

☐ Asthma	☐ Diabetes	☐ Mental health disorder	☐ Thyroid
☐ Aneurysm	☐ Heart problems	☐ Multiple Sclerosis	☐ Other _____
☐ Autoimmune disease	☐ High blood pressure	☐ Psychiatric disease	☐ None
☐ Cancer	☐ Kidney disease	☐ Stroke	

Please describe (include condition and family member):

_____
_____
_____

Patient Health History

Please check any problems or conditions, that you are experiencing or have experienced. If you do not have any of the problems listed in the section, please check none.

GENERAL HEALTH
- ☐ Recent weight change
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Fever/Chills

EARS, NOSE, MOUTH, THROAT
- ☐ Difficulty swallowing
- ☐ Earaches
- ☐ Loss of hearing/deafness
- ☐ Painful chewing
- ☐ Ringing in ears
- ☐ Sinus infection
- ☐ Sores in mouth
- ☐ Other _____
- ☐ None

EYES
- ☐ Blind Spots
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Glaucoma
- ☐ Injury
- ☐ Pain
- ☐ Other _____
- ☐ None

GASTROINTESTINAL
- ☐ Blood in stools
- ☐ Increasing constipation
- ☐ Nausea
- ☐ Painful bowel movements
- ☐ Persistent diarrhea
- ☐ Stomach or abdominal pain
- ☐ Ulcer
- ☐ Vomiting
- ☐ Other _____
- ☐ None

CARDIOVASCULAR
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Other _____
- ☐ None

GENITOURINARY
- ☐ Blood in urine
- ☐ Female: irregular periods
- ☐ Female: #pregnancies _____
  #miscarriages _____
- ☐ Male: prostate disease
- ☐ Male: testicle pain
- ☐ Kidney stones
- ☐ Painful or burning urination
- ☐ Sexual difficulty
- ☐ Sexually transmitted disease
- ☐ Urgency with urination
- ☐ Urine retention/incontinence
- ☐ Other _____
- ☐ None

MUSCLES/JOINT/BONES
- ☐ Back pain
- ☐ Difficulty walking
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Muscle pain or tenderness
- ☐ Neck pain
- ☐ Other _____
- ☐ None

PULMONARY
- ☐ Asthma
- ☐ Blood in cough
- ☐ Chronic or frequent cough
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Other_____
- ☐ None

PSYCHIATRIC
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Eating disorder
- ☐ Other _____
- ☐ None

NEUROLOGICAL
- ☐ Balance trouble
- ☐ Difficulty speaking
- ☐ Difficulty walking
- ☐ Facial drooping
- ☐ Fainting
- ☐ Headaches/migraines
- ☐ Injury to the brain/spine
- ☐ Lightheaded or dizziness
- ☐ Memory loss
- ☐ Ministroke/TIA
- ☐ Neuropathy
- ☐ Numbness or tingling
- ☐ Paralysis
- ☐ Stroke
- ☐ Tremors
- ☐ Weakness
- ☐ Other _____
- ☐ None

Are you? ☐ right-handed
☐ left-handed
☐ both

SKIN
- ☐ Changing moles
- ☐ Hair loss
- ☐ Infections
- ☐ Rash or itching
- ☐ Other _____
- ☐ None

SLEEP
- ☐ Snoring
- ☐ Sleep walking
- ☐ Nightmares

Do you sleep well?
☐ Yes ☐ No

Do you feel rested when you wake?
☐ Yes ☐ No

Do you fall asleep during the day?
☐ Yes ☐ No

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We'd like to update your social history at today's visit!

Please circle/fill in the answer to the following questions:

Legal Marital Status: Single Married Divorced Widowed

Who lives with you: Spouse Alone Children Other?

If Other, explain: _____

Highest level of education:

8th grade High School Some college (how many years _____)

Associate's Bachelor's Master's Doctorate +

Occupation: Unemployed Retired Disabled

Employed (Title _____ Where_____)

Alcohol Intake: None Occasional/Socially Regular use: # of drinks per day _____

Tobacco Use: Never

Former Tobacco User: (smoked how many packs a day for how long?) _____

Current Tobacco User: (how many packs a day for how long?) _____

Other Tobacco Use: please specify_____

Illegal Drug Use: Never

Former User: (What did you use?) _____

Current User: (What do you use?) _____

Are you sexually active? Never Not currently Yes

Any family history of mental illness or substance abuse? No

If yes, please explain: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if 1 place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below: I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9b

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date)_____ to (insert date)_____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (Indicate by Initialing)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials Name of individual health care provider to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Finn Name or Governmental Agency Name)

10. Reason for release of information: ☐At request of individual ☐Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.