HIGHGATE
medical group

1150 Youngs Rd
Williamsville, NY 14221
Phone: (716) 636-7979
Fax: (716) 929-0192

Suite 104 & 207

3950 E. Robinson Rd
W. Amherst, NY 14228
Phone: (716) 564-1111
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Suite 106 & 207

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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www.highgatemedical.com

TRANSITIONING FROM A PEDIATRIC PATIENT TO AN ADULT PATIENT

Highgate Medical Group, P.C., is a family medicine practice treating all patients age 6 and older.

It is our goal to provide a smooth transition from childhood to adolescence and beyond. We want our patients to know that their privacy is secure and that our staff at Highgate Medical Group is here to help with all needs, including:

- Illness and injury
- Wellness visits, such as sports physicals and check-ups
- Referral to specialists, if needed
- Medication Management
- Health Insurance
- Social Issues
- School/Work forms

We want to instill in our next generation the importance of having a primary care physician to maintain physical and mental health. It is best to be seen yearly for wellness appointments, even when in good health, so that any ailments can be treated quickly and appropriately as they may develop.

Our office actively participates in a medical home model. Our online patient portal is a tool to assist in scheduling appointments, retrieving test results, and communicating with your clinician as the need arises. Patients above the age of 13 will be given the opportunity to manage their own patient portal.

Thank you, and remember, we are here for you!

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PATIENT REGISTRATION

Patient Name: _____Date of birth: _____

Mailing Address: _____

Phone Number: _____ Phone Carrier: _____

Pharmacy Name & Address: _____

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: _____

Mother's Name: _____

Address (if different from above):

_____

Telephone: _____

Father's Name: _____

Address (if different from above):

_____

Telephone: _____

Guardian's Name (if different from birth parents): **_____** Relationship: _____

Address (if different from above):

_____

Telephone: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Insurance Name: _____ ID # _____

Subscriber Name: _____ Relation: _____

Employer: _____ Occupation: _____

Secondary Insurance Name: _____ ID # _____

Subscriber Name: _____ 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 the visit today? (Please describe the problem in detail):

_____
_____

Birth History:

Pregnancy complications _____
_____
Delivery complications □ Preterm or □ Full term _____
_____

Patient Medical History: Please check all that apply

□ Asthma	□ Eczema/Skin condition	□ Gastrointestinal problem	□ Other _____
□ Anemia	□ Epilepsy/Seizures	□ Psychiatric disease	_____
□ Concussion	□ Headache/Migraine	□ Thyroid	_____
□ Diabetes	□ Heart problems	□ UTI	□ None

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 (attach list)

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

Allergies: please list any allergies and reaction

_____
_____

Immunizations: Up to date? □ **YES** □ **NO** Please bring immunization record to appointment

Social History:

School and grade _____
Smokers in the household? □ **YES** □ **NO** If yes, who? _____
Pets in the household? □ **YES** □ **NO** If yes, which? _____
Other caretakers? □ **YES** □ **NO** If yes, who? _____

Family History: Any blood relative with the following

□ Asthma	□ Cancer	□ Inflammatory Bowel Disease	□ Psychiatric Disease
□ Aneurysm	□ Diabetes	□ Kidney Disease	□ Thyroid Disease
□ Autoimmune disease	□ Headache/Migraine	□ MS	□ Other: _____
□ Blood disorder	□ High Blood Pressure	□ Stroke	□ None

Please describe (condition and family member affected):

_____
_____
_____

Review of Symptoms: Please check any current or past problems or conditions

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

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

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

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

GENITOURINARY
- ☐ Blood in urine
- ☐ Female: irregular periods
- ☐ Female: #pregnancies _____
  #miscarriages _____
- ☐ Male: testicle pain
- ☐ Painful or burning urination
- ☐ Sexually transmitted disease
- ☐ Kidney stones
- ☐ Other _____
- ☐ None

CARDIOVASCULAR
- ☐ Pain in chest
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Other _____
- ☐ None

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

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

PSYCHIATRIC
- ☐ ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Eating Disorder
- ☐ Other _____
- ☐ None

NEUROLOGICAL
- ☐ Black outs/loss of consciousness
- ☐ Difficulty speaking
- ☐ Difficulty walking
- ☐ Headaches
- ☐ Injury to the brain/spine
- ☐ Lightheaded or dizziness
- ☐ Memory loss
- ☐ Numbness or tingling
- ☐ Paralysis
- ☐ Stroke
- ☐ Tremors
- ☐ Other _____
- ☐ None

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

SKIN
- ☐ Rash or itching
- ☐ Sun sensitivity
- ☐ Hair loss
- ☐ Other _____
- ☐ None

SLEEP
- ☐ Snoring
- ☐ Sleep walking
- ☐ Nightmare

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.