NORTH COAST INTERNAL MEDICINE, P.C.
CHARLES A. GAMBINO, D.O

207 Glen Cove Avenue • Sea Cliff, NY 11579 • (516) 676-1742

Whom may we thank for referring you? _____

Date _____ Patient Name _____ Age _____
First MI Last

SS # _____ Birthdate _____ Home phone _____ Cell _____

Address _____ City _____ State _____ Zip _____

Employment Status: ☐ FT ☐ PT ☐ Unemployed ☐ Student ☐ Retired ☐ Self-employed

Gender at Birth ☐ F ☐ M How do you identify yourself? _____

Email _____

Patient's employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or parent/guardian's name _____ Employer _____ Work phone _____

Person to contact in case of emergency _____ Phone _____

In case of a medical emergency, if the patient is of school age 1 5 +, it is all right to treat in my absence.

X _____ _____
Parent or guardian signature Date

Insurance Information

Name of insured _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ SS # _____ Date employed _____

Name of employer _____ Work phone _____ Home phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Ins. I.D. # _____ Group# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ SS # _____ Date employed _____

Insurance company _____ Ins. I.D. # _____ Group# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

I hereby authorize this medical facility and its representatives to release any information acquired in the course of my exam or treatment to any insurance carriers needed for the processing of insurance claims. I permit a copy of this authorization to be used in place of the original for the term of services provided to me and/or my partner.

I hereby assign all payments of medical benefits, to include Major Medical benefits to which I am entitled including Medicare, Private insurance and any other plans to this facility. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance including all legal fees incurred in collection of unpaid charges. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

I have read and understood the above:

Patient Signature: _____ Date: _____

Medical Information Release Form
HIPAA Release Form

Name: _____ **Date of Birth:** ___/___/_____

We are unable to discuss your treatment with anyone unless you give us written permission.

[ ] **I authorize the release of information including the diagnosis, records, images, examination rendered to me. Please list the name(s) of person(s) below:**

Name: _____ Relation: _____ Telephone #: _____

Name: _____ Relation: _____ Telephone #: _____

Name: _____ Relation: _____ Telephone #: _____

or
[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call my: [ ] home [ ] cell [ ] work Telephone **#:** _____

If unable to reach me:
[ ] You may leave a detailed message
[ ] Please leave a message asking me to return your call
[ ] Other: _____

The best time to reach me is (day) _____ between (time) _____

I have received a copy of this office's Notice of Privacy Practices.

Signed: _____ **Date:** _____

CANCELLATION/MISSED APPOINTMENT POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment cancellation policy. This policy enables us to better utilize available appointments for our patents needing immediate care.

Cancellation of an appointment:
In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to cancel your appointment:
To cancel appointments, please call 516-676-1742. If you do not reach receptionist, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone and let us know the best time to return your call.

No-Show Policy:
A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. "No-shows" inconveniences those individuals who need access to medical care in a timely manner, as well as the physician. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show", there will be no charge to the patient. Any additional "no-shows" will result in a fee of $25.00 for regular appointments and $50.00 for Complete physical exams. A credit card authorization form or $50 deposit will also be required prior to future appointments. If a patient accumulates 3 "no-shows", he/she mat be asked to leave the practice.

Late Cancellations:
Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed as a cancellation fee.

I understand this policy and authorize to assess cancellation and "no-show" fees according to the above outlined policy to the credit card listed below.

_____

Patient (or responsible financial party)

_____

Signature Date

_____

Printed Patient name

Credit card information ____ M/C _____Visa ____Discover _____Amex
Number: _____
Expiration_____ CVV_____

Signature_____

North Coast Medical Group

Name SS# — — Date of birth / /

Address City State Zip

Phone ( ) Work Phone ( ) Emergency Contact

Allergies Pharmacy # ( )

Date	Medications	Dosage	Sig

Flu vax given on 2009 10 11 12 13 14 15 16 17 18

Pneum vax (Q 5yrs) ______, ______, ______, ______, ______,

Tetanus (Q 10 yrs) ______, ______, ______,

______, ______, ______, ______, ______

Hep B vax 1st dose ______
2nd dose ______
3rd dose ______

Mammo NL / Abnl NL / Abnl
NL / Abl NL/ Abnl NL / Abnl
NL / Abl NL/ Abnl NL / Abnl

Pap smear NL / Abnl NL / Abnl
NL / Abl NL/ Abnl NL / Abnl
NL / Abl NL/ Abnl NL / Abnl

PSA ______, ______, ______, ______, ______
______, ______, ______, ______, ______, ______

CXR ______, ______, ______, ______, ______,

PPD ______, ______, ______, ______, ______,

Colonosopy ______, ______, ______, ______,

PAST MEDICAL HISTORY

DATE		DATE	

We are authorized to discuss results with Name____________ Phone#____________