Internal Medicine
Nady R. Shehata, M.D.
President
Nancy J. Peters, M.D.
Andrew W. Warner, M.D.

Family Practice
Albert J. Addesa, Jr., M.D.
Jacqueline M. Heim, D.O.

Nicole M. Maul, PA-C
Maegan E. Olson, PA-C
Kaylin C. Moore, PA-C
Nathan D. Rush, PA-C

Associated Physicians of Western New York, P.C.

Internal Medicine / Family Practice

James P. Giambrone, M.D.
Physician Emeritus

Diane R. Wojtan
Office Manager

RoseAnn Cybulski, R.N., BSN
Nurse Manager

PLEASE READ IMMEDIATELY

Date: _____

Dear: _____

Our records indicate that your initial visit to our office is scheduled

on _____ with Dr. _____.

For your first visit to proceed smoothly, we are requesting that you complete the enclosed five (5) forms **PRIOR** to your appointment. **On the day of your appointment, we ask that you arrive 10-15 minutes early.** Please bring the forms, your driver's license (or photo ID), your insurance card and your actual medication bottles or anything you take over the counter with you.

PLEASE NOTE: If you subscribe to an HMO insurance, it will be necessary for you to have selected a Primary Care Physician (PCP) from this office prior to your appointment in order for your visit to be covered. Be advised that any co-payment or monies due, are payable at the time of service. We do not bill for co-payments. We accept cash, checks, debit and most major credit cards.

For your convenience, we have enclosed a copy of our practice brochure. Please take a few moments to read over our office policy before your appointment and address any concerns you may have with our office staff.

If for any reason you are unable to keep your scheduled appointment, please call the office as soon as possible to inform our staff to cancel. These appointments are saved for you and require extensive time. We will telephone to confirm your appointment 48-72 hours prior. It is necessary for you to return the call and let us know that you will be keeping this appointment or it will automatically be cancelled. Please be sure to contact the office to acknowledge your appointment as instructed.

UNCANCELLED NEW PATIENT APPOINTMENTS THAT ARE MISSED WILL NOT BE RESCHEDULED.

Thank you in advance for your cooperation.
Front Desk Reception Staff

1616 Kensington Avenue
Buffalo, New York 14215
(716) 835-3097
Fax (716) 837-4654

2805 Wehrle Drive, Ste. 10
Williamsville, NY 14221
(716) 683-5252
Fax (716) 683-6885

Associated Physicians of Western New York, P.C.

Internal Medicine/Family Practice

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone #:_____Cell Phone #:_____Sex:_____

Marital Status:_____Birth Date:_____Social Security #:_____

Email Address:_____

Employer Name:_____

Occupation:_____ Employer Phone #:_____

Emergency Contact Name: _____
(PLEASE SELECT SOMEONE OUTSIDE OF YOUR HOUSEHOLD AND ON CONSENT FORM)

Contact Phone #:_____ Relationship:_____

Who referred you to this office?_____

Pharmacy Name: _____

Pharmacy Address: _____

Authorization to release information: I hereby authorize the physician to release any necessary information acquired during treatment to process insurance claims.

Signature:_____ Date: _____

Authorization to pay benefits to physician: I hereby authorize the insurance company to pay medical benefits directly to the physician, if any are paid. If the insurance company does not pay the claim, I realize I may be responsible for non-covered services.

Signature:_____ Date:_____

Updated 02/06/15

ASSOCIATED PHYSICIANS OF WNY, P.C.

General Information Sheet

Please answer the following questions prior to your first examination so we can better serve you.

NAME: _____ DOB: _____ AGE: ____

PHONE NUMBER: _____ PLACE OF BIRTH (COUNTRY): _____

ADDRESS: _____

HIGHEST EDUCATION LEVEL: _____ OCCUPATION: _____

PREVIOUS PRIMARY CARE PHYSICIAN: _____

MEDICAL DIAGNOSES: Please include all medical problems that you are currently being treated for or have been treated for in the past.

_____

_____

_____

MEDICATIONS: Please list all medications including over the counter medications and vitamins/minerals. If needed, please attach a list.

MEDICATION	DOSE	REASON FOR TAKING	PREVIOUS/CURRENT PRESCRIBER

ALLERGIES: Please include medications you are allergic to and the reaction you had to them.

_____

PAST SURGERIES: _____

_____

FAMILY HISTORY:

Father: Alive [ ] or Deceased [ ] Current/Past Medical Problems: _____

_____

Mother: Alive [ ] or Deceased [ ] Current/Past Medical Problems: _____

_____

Siblings: Current/Past Medical Problems: _____

Children: Current/Past Medical Problems: _____

Other Family Members (grandparents, aunts/uncles, etc) _____

OVER

SOCIAL HISTORY:

Do you currently smoke? YES [ ] NO [ ]

If YES: How many packs per day and for how many years? _____

Any interest in quitting? _____

If NO: Have you in the past? _____

How long has it been since you quit? _____

How much did you used to smoke and for how many years? _____

Any alcohol use? YES [ ] NO [ ]

If YES: How many times a week do you drink? _____

How many drinks per occasion? _____

Do you ever drink more than 6 drinks per occasion? _____

Do you use any recreational or illegal drugs? YES [ ] NO [ ]

SPECIALISTS: If you follow with any other physicians currently, please list them below and include what you are seeing them for. Women, please include your OBGYN.

PHYSICIAN: REASON FOR SEEING:

_____

_____

_____

_____

_____

Health Care Proxy: If you have a health care proxy, please include their name here

_____

PREVIOUS VACCINATIONS: Please include the dates of previous vaccinations if received.

Influenza Vaccine: _____

Pneumonia Vaccine: _____

Shingles Vaccine: _____

PREVENTATIVE MEDICINE: Please include the dates of all of the following procedures if received.

Mammogram (women only): _____

Pap Smear (women only): _____

Colonoscopy (men and women over 50): _____

Bone Density Scan (women over 65): _____

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To Our Patients:

It is necessary for us to have written consent in your medical file if you want us to be able to communicate any medical information about yourself to another individual. If you want us to release information to a family member, such as a spouse, a significant other, a parent or sibling, or any other individual, you must indicate the name of that specific person(s). WE WILL BE UNABLE TO RELEASE ANY INFORMATION TO ANYONE OTHER THAN WHO IS INDICATED ON THIS FORM.

I, _____, hereby give my permission for the staff of
(Your Name)

Associated Physicians of WNY to release medical information about myself to:

_____
(Name of person you are authorizing) (Relationship) Phone#

_____
(Name of person you are authorizing) (Relationship) Phone#

I may cancel this authorization at any time by written notification.

Signature: _____ Date Signed: _____

**** IF YOU DO NOT WANT TO AUTHORIZE THE RELEASE OF YOUR MEDICAL INFORMATION TO ANY INDIVIDUAL, PLEASE SIGN BELOW.**

I, _____, decline to have any medical
(Your Name)

information released to any individual.

Signature: _____ Date Signed: _____

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ASSOCIATED PHYSICIANS OF WESTERN NEW YORK, P.C.
1616 Kensington Ave., Buffalo, NY 14215

Consent to Use and Disclose Protected Health Information

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
Your protected health information will be used by **Associated Physicians of WNY, P.C.** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

THE NOTICE OF PRIVACY PRACTICES
Associated Physicians of WNY, P.C. is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. **PLEASE REVIEW IT CAREFULLY.**

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION
You may request a restriction on the use or disclosure of your protected health information. However, **Associated Physicians of WNY, P.C.** may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request.

It is a violation of the federal privacy standards if **Associated Physicians of WNY, P.C.** agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request.

YOU MAY REVOKE THIS CONSENT AT ANYTIME
You may revoke this consent at anytime; however, **Associated Physicians of WNY, P.C.** requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES
Associated Physicians of WNY, P.C. reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Brochure. **Associated Physicians** will notify you of any changes of privacy practices either by mail or at your next appointment.

SIGNATURE
I have reviewed this consent form, received the brochure entitled "Notice of Privacy Polices and Practices" and give my permission to **Associated Physicians of WNY, P.C.** to use and disclose my health information in accordance with this consent and the notice provided.

Name of Patient (Print or Type)	Signature of Patient / Date
Patient Representative (Print or Type)	Signature of Representative / Date
Relationship of Patient Representative to Patient	

Preventative Measure Information Sheet

Patient Name: _____ DOB: _____ Todays Date: _____

As part of our Patient Centered Medical Home Standards we need to update some pertinent information in your medical record. As with all of your information everything is confidential. Please direct any questions to the Nurse or Provider.

- Preventative measures: Date Where

  Pap Smear---

  _____

  Mammogram---

  _____

  Colonoscopy---

  _____

  Dental---

  _____

  Bone Density---

  _____

  Diabetic Eye Exam---

  _____

- Family History:
  - Do you have any family history of Mental Health issues? Yes No
  - Do you have any personal history of Mental Health issues? Yes No
  - Do you have any family history of Substance/Alcohol abuse? Yes No
  - Do you have any personal history of Substance/Alcohol abuse? Yes No
- Advance Directives-please complete before you leave today. If you already have one in your medical record, please advise us if anything has changed.

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Williamsville, New York 14221
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Fax 716-683-6885

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form provides authorization to our practice to use or disclose certain of your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

Patient Name:_____ DOB: _____

Address: _____

- Who will be disclosing the information? Name of person or entity, or category of persons/entities authorized to make the requested use of disclosure:

_____

_____

- Who will be receiving or using this information? Name of person or entity, or category of persons/entities, to whom the use of disclosure may be made:

_____

_____

- What information will be used or disclosed? The following is a specific description of the information to be used or disclosed, but not limited to, the date(s) of service provided, level of detail to be released, origin of information, etc.:

_____

_____

- What is the purpose of the use and disclosure? This information is being used or disclosed for the specific purpose(s) below. If you have requested use or disclosure of the information but do not, or elect not to, provide a statement of purpose, we will state "at the request of the individual".

_____

_____

This authorization will expire on (Date): _____

Signatures: I have read and understand the terms of this authorization, and I understand that I may revoke this authorization in writing to the appropriate person.

_____ _____

Patient – Print name above Date

_____

Patient Signature

_____ _____

Witness Signature Date

Revised 03/21/13