ROCKLAND PULMONARY & MEDICAL ASSOCIATES

Welcome To Our Practice

We hope that the following information will be helpful in making your visit easy.

We have 3 locations:

2 Crosfield Avenue Suite 318 West Nyack, NY 10994	257 Lafayette Avenue Suite 340 Suffern, NY 10901	27 Liberty Square Mall Stony Point, NY 10980

Our Telephone number is 845-353-5600, phones are on:

Monday – Thursday	8:00 AM- 5:00 PM
Friday	8:00 AM- 4:00 PM

SAME DAY* Sick/Urgent Appointment line is open between 8:30AM -3 PM.

Call main number 845-353-5600 and press option 3.

**If we are unable to accommodate you for a same day sick appointment we will schedule you for the first appointment on the following day.*

Our office Hours are:

Monday- Wednesday		8:00 AM- 7:00 PM
Thursday		8:00 AM- 6:00 PM
Friday		8:00 AM- 4:00 PM
Sat & Sun	**Suffern location ONLY**	9:00 AM -2:00 PM

Weekend appointment Line **845-533-7120** opens between 9am- 1pm
Appointments are preferred on weekdays and weekends but Walk-in appointments for same day appointments are available on,
Saturday and Sunday only at our Suffern location **(for URGENT/SICK primary care patients only).**

We will do our best to give you the provider you request with a priority for annual physical and follow up visits.
In some cases, especially when you need same day care, you may be offered an appointment with another provider.

Our doctors are on call after hours for urgent problems.
Please call (845)353-5600, and our answering service will connect you with the provider on-call.

For your convenience we have enclosed the following forms to be completed by you before your scheduled appointment.

Please bring with you to your upcoming visit.

Please arrive 30 minutes early for registration.

On the day of your appointment, please make sure that you bring your insurance card, photo ID and referrals if needed.

REGISTRATION

Last Name: _____ First Name: _____ MI _____

DOB _____/_____/_____ Gender: ☐ Male ☐ Female ☐ Other SSN: _____-_____-_____ __

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native

☐ Native Hawaiian/Other Pacific Islander

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other: _____ Language: _____

Mailing Address: _____

Home Phone: _____ Mobile Phone: _____

Email Address:_____@_____ ☐ None ☐ Decline

Employed: ☐ Employer_____Occupation:_____

Student ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disabled

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____

Primary Doctor _____ Phone: _____

Please check as they apply to you. If you have any questions please speak with your Provider

Do you have? ☐ **Health Care Proxy** ☐ **Durable Power of Attorney** ☐ **Advanced Directive**

Can you provide a copy ☐ Yes ☐ No

Name of Legal Guardian or Health care proxy _____

Relationship to patient: _____Phone: _____

Primary caregiver: provides day to day care for patient and receives instructions about care ☐ None ☐ Yes

Caregiver Name _____Phone:_____

Relationship to patient _____

Turn over to continue on back page

REGISTRATION

WORKERS COMP/NO FAULT: Is this visit under workers comp/no faults? YES _____ NO _____

Claim Number: _____

PLEASE GIVE INSURANCE CARD TO REGISTRATION STAFF

Primary Ins. Plan Name _____ Ins. Phone _____

Policy I.D._____ Group # _____

Policy Effective Date _____ Relationship to Policy Holder _____

Policy Holder Name _____ Policy Holder DOB: _____

Policy Holder Address _____ ☐ Same as Patient

Policy Holder SSN:_____ - _____ -_____

Secondary Ins. Plan Name _____ Ins. Phone _____

Policy I.D._____ Group # _____

Policy Effective Date _____ Relationship to Policy Holder _____

Policy Holder Name _____ Policy Holder DOB: _____

Policy Holder Address _____ ☐ Same as Patient

Policy Holder SSN:_____ - _____ -_____

Turn over to continue on back page

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Bon Secours Medical Group
A Member of the Westchester Medical Center Health Network

MRN: _____

PATIENT NAME: _____ DOB: _____
(PLEASE PRINT)

ALLERGIES TO MEDICATION:

☐ **NOT TAKING ANY MEDICATIONS**

Pharmacy: _____ Tel. _____

MEDICATION	STRENGTH	HOW OFTEN

2 Crosfield Avenue Suite 318 West Nyack, NY 10994
257 Lafayette Avenue, Suite 340 Suffern, NY 10901
27 Liberty Square Mall, Stony Point NY 10980
Tel: (845) 353-5600 Fax: (804) 261-4904

Practice Communication and Personal Health Information (PHI) Form

By completing this form you will be granting Bon Secours Medical Group permission to release your Protected Health Information (PHI) to one or more personal representatives and/or to communicate with you in certain ways. Only the information indicated below will be released to your personal representative and/or communicated to you in the manner specified. This authorization is valid for one year from the date signed and will be renewed by the practice on a yearly basis. If at any time you would like to modify or revoke this permission you may do so by contacting the practice.

Patient Name: _____ Patient DOB: _____

Home Phone_____ Mobile Phone _____ Work Phone _____

Patient Address: _____

I request and authorize Bon Secours Medical Group to disclose and/or release my protected health information (PHI) to:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____

This authorization applies to :(check all that apply)

___ Healthcare Information

___ Demographic Information

___ Mental Health Information

___ HIV Information

___ Alcohol/Drug Treatment Information

___ Financial Information

___ Other Information Please Specify

_____

_____

_____

I hereby authorize Bon Secours Medical Group to:

Leave a message on my [ ] home [ ] business [ ] cellular telephone answering machine/voicemail, this message may contain my protected health information (PHI).

I also authorized Bon Secours Medical Group to contact _____ at the following number _____ in case of an emergency or to contact me regarding urgent medical issues.

I have carefully read and understand the above authorization. This authorization applies to all medical offices within the Bon Secours Medical Group, unless otherwise specified. I also understand that this authorization may be revoked at any time by contacting the practice administrator.

Printed Patient Name: _____

Patient Signature: _____

Authorization Date: _____ Expiration Date: _____
(One year after authorization date)

Patient Health Questionnaire (PHQ-9)

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Westchester Medical Center Health Network

Patient Name: _____ Date of Visit: _____

DOB: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?		**Not At All**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things.		0	1	2	3
2. Feeling down, depressed, or hopeless.		0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much.		0	1	2	3
4. Feeling tired or having little energy.		0	1	2	3
5. Poor appetite or overeating.		0	1	2	3
6. Feeling bad about yourself- or that you're a failure or have let yourself or your family down.		0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television		0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite- being so fidgety or restless that you have been moving around a lot more than usual.		0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way.		0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very Difficult ☐ Extremely difficult

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Patient Name: _____ DOB: _____

List of Physicians and consultants whom you are seeing

Consultant	**Name (s)**
Cardiology (heart)	
Pulmonary (Lungs)	
Gastroenterology (stomach)	
Nephrology (kidneys)	
Neurology (brain)	
Endocrinology (diabetes/thyroid)	
Oncology (Cancer)	
GYN (female)	
Urology (prostate/urinary)	
Dermatology (skin)	
ENT (ears,nose,throat,allergy)	
Surgeon	
Ophthalmology/Optometry (Eye doctor)	
Podiatry (Foot)	
Other:_____	

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Patient Name: _____ DOB: _____

Health Maintenance Checklist

TEST	DATE	PLACE/DOCTOR
Mammogram Women 40yo and older annual		
Colonoscopy Age 50, repeat interval per GI specialist		
Bone Density Women age 65yo Repeat interval determined by doctor		
Pap smear Women 21-65yo every 3 years (or interval per GYN)		
Eye Exam Diabetics annual Glaucoma screen		
Recent Immunizations Flu/pneumonia/zoster		
Living Will or Advanced Directive		**If you have one please bring a copy to your visit**