Wayside Health Associates

NEW PATIENT REGISTRATION

Jay B. Krasner, MD, FACP
Internal Medicine and General Practice
111 Boston Post Road Suite 107
Sudbury, MA 01776
Phone: (978) 443-8010
Fax: (978) 443-4634

General Information
Last Name
First Name
Middle Name
Sex
Previous Last Name
Date of Birth
Social Security #
Address
Address (Line 2)
City
State
Zip
Home Phone
Work Phone
Mobile Phone
Email
Contact Preference
Marital Status
Pronouns

Insurance Information
Insurance Plan
Address
Address (Line 2)
City
State
Zip
Phone
Patient ID #
Group #

How did you hear about the practice?

Guardian
Last Name
First Name
Middle Name

Emergency Contact
Name
Relation
Phone

Next of Kin
Name
Relation
Phone

Employer
Name
Phone
Occupation

Guarantor/Policy Holder (if not self)
Relation
Last Name
First Name
Middle Name
Sex
Date of Birth
Address
Address (Line 2)
City
State
Zip
Social Security #
Employer name
Employer Phone

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Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Jay B. Krasner, MD for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Jay B. Krasner, MD to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Jay B. Krasner, MD on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that Jay B. Krasner, MD reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

_____ _____

Signature Date

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Health History (1)

Your answers on this form will help us understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. Thank you!

Personal Medical History – Please note (x) if you have had any of the following medical problems					
	Alcohol dependence		Anemia		Anxiety disorder
	Asthma		Autoimmune disorder		Bleeding/clotting problems
	Cancer		Colitis		Depression
	Diabetes		Epilepsy/seizures		Emphysema/COPD
	Eye problems		Heart Disease		Hepatitis
	High cholesterol		HIV/AIDS		Hypertension
	Kidney disease		Kidney Stones		Migraine
	Neurologic problems		Skin disorders		Substance abuse
	Thyroid problem		Other:		

If any of the above are checked, please provide details

Surgeries and Hospitalizations (with dates)

Family History				
	If Living		If Deceased	
	Age(s)	Health Problems	Age At death	Cause of death
Father				
Mother				
Siblings				
Children				

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Health History (2)

Current Medications – include vitamins, supplements and nonprescription medications		
Name	Dose/strength/how often	How long taken?

Allergies (medications, chemicals, foods, etc.) and type of reaction

Health Habits	
Dietary preference (vegan, etc.)	
Hours of sleep nightly	
Exercise duration & frequency	
Daily alcohol use	
Daily tobacco use	
Daily cannabis use	
Last routine physical exam	

Use this space to give more details or add medical information not listed above: