SHERRELL J. ASTON, M.D., F.A.C.S.
728 PARK AVENUE NEW YORK, NY 10021 • Tel: 212-249-6000 Fax: 212-879-9797

DATE: _____

PATIENT INFORMATION

FULL NAME *(AS IT APPEARS ON LEGAL DOCUMENTS)* : _____

BIRTHDATE: _____/_____/_____ AGE: _____

ADDRESS:_____

CITY:_____STATE:_____ZIPCODE:_____

IF YOU ARE VISITING NEW YORK, WHAT IS YOUR LOCAL ADDRESS:

_____

HOME PHONE:_____CELL PHONE: _____

MARITAL STATUS: _____ NAME OF SPOUSE:_____

EMAIL ADDRESS: _____

I MAY BE CONTACTED BY EMAIL: ☐YES ☐NO

OCCUPATION: _____ EMPLOYER: _____

WORK PHONE:_____ WORK ADDRESS:_____

REFERRED BY:_____ RELATIONSHIP:_____

EMERGENCY CONTACT:_____ RELATIONSHIP TO PATIENT:_____

EMERGENCY CONTACT PHONE: _____

PERSON RESPONSIBLE FOR BILL: _____

PHARMACY: _____ PH:_____ZIP: _____

PLEASE BE ADVISED THAT DR. ASTON DOES NOT PARTICIPATE WITH ANY INSURANCE COMPANIES OR PLANS INCLUDING BUT NOT LIMITED TO WORKER'S COMPENSATION OR MEDICARE.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT:

PATIENT SIGNATURE:_____ DATE:_____

PRINT NAME:_____

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MEDICAL HISTORY:

DO YOU HAVE A HISTORY OF THE FOLLOWING? Please check all that apply

☐HEART DISEASE
☐ANEMIA
☐THYROID DISORDERS
☐SEIZURES
☐ASTHMA
☐SINUS PROBLEMS
☐CANCER
☐DIABETES
☐HEPATITIS
☐SLEEP APNEA
☐STROKE
☐BLOOD CLOTS
☐PHLEBITIS
☐VARICOSE VEINS
☐BLEEDING DISORDERS
☐ HIV/AIDS

DO YOU CURRENTLY SMOKE?:_____IF YES, HOW MUCH:_____

HAVE YOU EVER SMOKED?:_____IF YES, FOR HOW LONG?:_____

PLEASE LIST ALL PREVIOUS AND CURRENT MEDICAL CONDITIONS: _____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?: Please check all that apply

☐PENICILLIN
☐SULFA DRUGS
☐LATEX
☐ADHESIVE TAPE
☐ANTIBIOTIC OINTMENT

PLEASE LIST ANY OTHER ALLERGIES:_____

SURGICAL PROCEDURES: Please list year and name of surgeon; including cosmetic surgery

_____

HOSPITALIZATIONS: Please include year and reason

_____

_____

MEDICATIONS: Please include name, frequency and dosage:_____

_____

HERBAL AND HOLISTIC MEDICATIONS: Please list all over the counter medications you take including vitamins and minerals: _____

FAMILY HISTORY:

DIABETES:_____ HEART DISEASE:_____CANCER:_____

BLEEDING DISORDERS:_____

HAVE YOU HAD A PHYSICAL EXAM IN THE LAST YEAR?:_____ HEIGHT:_____ WEIGHT:_____

PRIMARY CARE PHYSICIAN:_____PHONE:_____

CARDIOLOGIST:_____PHONE:_____

PULMONOLOGIST:_____PHONE:_____

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ACKNOWLEDGEMENT OF RECIPT OF PRIVACY NOTICE:

By signing this form, you acknowledge that Sherrell J. Aston MD, PC has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

By law, we must try to have you sign this form on your first date of service with us. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ]I have received Sherrell J. Aston MD, PC's Privacy Notice

[ ]I understand that I am responsible for the fees in advance as Dr. Aston does not participate with any type of insurance

Patient Signature: _____ **Date**: _____