REGISTRATION & PATIENT INFORMATION FORM

Last Name: ____________________________ First Name: ___________________________ M.I.: ______

D.O.B. _______________ Sex/Gender: ___________ SSN: _______-_____-_________

Street Address: ______________________________________ Home Phone: ________________________

______________________________________ Cell Phone: ________________________

City, State: ______________________________________ Zip Code: ________________________

Emergency Contact:

Name: ____ Home Phone: ________________________

Relationship: ______________________________________ Cell Phone: ________________________

Primary Care Physician:

Name:

____

Phone number/Address:

____

Preferred Pharmacy:

Name:

____

Phone number/Address:

____

I hereby authorize and direct Michael Arena, D.O., having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

____ ________________________
Signature of Patient or Personal Representative Date

____ ________________________
Print Name of Patient or Personal Representative Relationship to Patient

Patient Name

REGISTRATION & PATIENT INFORMATION FORM (PAGE 2)

Have you had or do you currently suffer from any of the following:

Headaches, seizures, or other neurological problems?	Yes ☐ No ☐
High blood pressure or other heart problems?	Yes ☐ No ☐
High cholesterol, high triglycerides, or obesity?	Yes ☐ No ☐
Problems with your stomach or with the digestive system?	Yes ☐ No ☐
A chronic or recurring skin condition?	Yes ☐ No ☐
Glaucoma or other serious eye or vision problem?	Yes ☐ No ☐
Respiratory problems including asthma, COPD, or emphysema?	Yes ☐ No ☐
Urinary or kidney problems (including prostate difficulties)?	Yes ☐ No ☐
Cancer or a blood disorder?	Yes ☐ No ☐
Liver problems?	Yes ☐ No ☐
An autoimmune disease?	Yes ☐ No ☐
Diabetes, thyroid dysfunction, or other endocrinological difficulties?	Yes ☐ No ☐
Gynecological problems including uterine, cervical, ovarian, or breast difficulties?	Yes ☐ No ☐
Any difficulties requiring surgery?	Yes ☐ No ☐
An allergic reaction to any food or medication?	Yes ☐ No ☐

If you answered yes to any of the above, please specify below and/or the back of the page.

____

____

____

Patient Name

REGISTRATION & PATIENT INFORMATION FORM (PAGE 3)

Are you pregnant or plan on becoming pregnant within the next 12 months? Yes ☐ No ☐

Are you now or planning to breast feed? Yes ☐ No ☐

Are you post menopausal? Yes ☐ No ☐

Are you a vegetarian or do you have any specific nutritional needs? Yes ☐ No ☐

Have you had any previous psychiatric treatment or psychotherapy? Yes ☐ No ☐

Have you ever been psychiatrically hospitalized? Yes ☐ No ☐

Have you ever received treatment for alcohol or substance abuse? Yes ☐ No ☐

Are you currently taking any medications (including over-the-counter or alternative medications and supplements)? Yes ☐ No ☐

If yes, please list them below (if you need more space, continue on the back):

Medication Name	Dose & Frequency	Prescribing Doctor

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient

Patient Name

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY AGREEMENT

I hereby consent to and authorize Michael Arena, D.O. to evaluate my medical condition and conduct any routine and non-invasive diagnostic and therapeutic procedures and treatment that, in Dr. Arena's judgment, are necessary for my care. I understand that I have a right to refuse any recommended treatment once it has been explained to me.

I understand that my treatment with Dr. Arena is on a fee-for-service basis and he does not accept medical insurance. I understand that I am responsible for any fees or charges incurred. That includes, but is not limited to, charges for any missed or canceled sessions, administrative fees, telephone sessions, and consultations with agencies or other practitioners.

I understand that I am obligated to give Dr. Arena at least 24 hours advance notice for any cancelled appointment and, if I do not provide advance notice, I will be charged for the time reserved. This charge will be equal to the usual and customary fee for the services scheduled.

Please note that Dr. Arena has privileges at Long Island Jewish Medical Center including the Zucker Hillside Hospital.

I have read the above information. My signature below indicates that I understand and accept these provisions.

Signature of Patient or Personal Representative | Date

Print Name of Patient or Personal Representative | Relationship to Patient

I hereby authorize Dr. Arena or his representatives to contact me via the telephone numbers I provided to discuss information about my health care, including leaving detailed voice mail messages which may contain information regarding my health care.

Signature of Patient or Personal Representative | Date

Print Name of Patient or Personal Representative | Relationship to Patient