DR. KENNETH BRESKY

HARMONY IN MOTION
Restoring Movement, Revitalizing Lives

(561) 740.4855

Fax: (561) 740.4855

Kenneth E. Bresky, D.O.,P.A.
Erica Edlund, APRN-C
Rheumatology and Medical Weight Management
6290 Linton Boulevard, Suite #102, Delray Beach, FL 33484

NEW PATIENT INFORMATION SHEET

Patient Name (PLEASE PRINT) _____
Date of Birth: ____/____/_____ SEX: Male / Female
Marital Status: Single Married Divorced Widow
Patient Address: (PLEASE PRINT) _____
City: _____, State: _____, Zip: _____
Home Phone #: _____
Cell Phone #: _____
Email Address: _____
Name of Physician who referred you _____
Employment Status: Retired / Employed / Not Employed / Student
Employer Name: _____ Phone Number: _____
Name of Primary Insurance:_____ ID# _____
Primary Physician Name: _____ Phone #: _____
Emergency Contact: _____ Phone #: _____
Relationship to Patient: _____

For all patients: I understand and agree that I am financially responsible for all charges incurred on my behalf. I authorize the release of any medical Information necessary to process my claims. I also authorize payment of medical benefits to the physician or supplier of service as indicated on claim. In the event it is necessary to refer my account to a collection agency or any attorney, I agree to pay all collection costs, including attorney fee's and court costs.

Whom may we share your medical billing information with:
Name: _____ Relationship: _____
Patient signature:_____ Today's Date: ____/_____/_____
Acknowledgment of Receipt of Notice of Privacy Practices

Notice to Patient: We are required to provide you with a copy of the Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of notice. I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature:_____ Today's date: ____/____/_____

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NEW PATIENT INFORMATION FORM

NAME:_____ **DATE OF BIRTH:**_____

FAMILY HISTORY:

	YES	NO	RELATION
HEART ATTACK	☐	☐	_____
HEART DISEASE	☐	☐	_____
DIABETES	☐	☐	_____
HYPERTENSION	☐	☐	_____
STROKE CANCER	☐	☐	_____
EMPHYSEMA	☐	☐	_____
THYROID	☐	☐	_____

FATHER: Alive ☐ Deceased ☐ Age: _____
Cause: _____

MOTHER: Alive ☐ Deceased ☐ Age:_____
Cause:_____

SIBLINGS:	**M**	**F**	**Age**	**Illness**
	☐	☐	_____	_____
	☐	☐	_____	_____
	☐	☐	_____	_____
	☐	☐	_____	_____

SOCIAL HISTORY:
Married: ☐ Divorced: ☐ Widow: ☐ Single: ☐
In Florida Since: _____ Originally From: _____
Local Residence: _____Children: _____
Other Residence: _____
Occupation:_____ Retired: YES ☐ NO ☐

PAST MEDICAL HISTORY	ILLNESS/SURGERY	MEDICATIONS	NAME/DOSE/FREQUENCY

ALLERGIES: (List NONE if No Allergies)

HABITS:
Smoking: Packs Per Day: _____ How Long: _____ Other:_____
Drinking: How Much:_____ How Long: _____
Dr. Signature:_____ Reviewed ☐ Revised ☐ Date: ____/____/_____

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Pharmacy Information

Today's date: _____

Patient's Name: _____ DOB: _____

Retail Pharmacy:

- Pharmacy's Name:_____
- Pharmacy Address: _____
- Phone: _____ Fax: _____

Mail Order Pharmacy:

- Pharmacy's Name:_____
- Pharmacy Address: _____
- Phone: _____ Fax: _____

Specialty Pharmacy:

- Pharmacy's Name:_____
- Pharmacy Address: _____
- Phone: _____ Fax: _____

Print Patient's Name: _____ Signature: _____

_____

Internal use ONLY:

Prescription Insurance's:
Name:_____ Member ID: _____
Phone:_____ Fax: _____ Website: _____
Prior Authorization Dept:
Phone:_____ Fax: _____ Website: _____

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Medical Record Release Form

Today's Date: _____

Patient Name:_____ DOB: _____

• I hereby authorize Dr. Kenneth E. Bresky DO, PA the use/ access/ disclosure of my protected health Information as described below.

• I understand that authorizing the disclosure of this health Information Is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

• I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Dr. Kenneth E. Bresky DO, PA office staff.

• I understand that the revocation will not apply to Information that has already been released in response to this authorization.

• I understand that the revocation will not apply to my Insurance company when the law provides my insurer with the right to contest a claim under my policy.

• I understand that I may inspect or obtain a copy of the Information to be used or disclosed, as provided in CFR 164.524,

• I understand the information In my health record may Include Information relating to AIDS, HIV, and/or sexually transmitted disease, psychiatric, alcohol or drug abuse/testing Information which may be protected by Federal and State Regulations.

• I understand that unless otherwise revoked, this authorization will expire upon the following date, event ar condition:_____. If no expiration date, event or condition is noted this authorization will expire In 1 year from the date signed.

• I understand that Dr. Kenneth E. Bresky is released from any legal responsibility or liability for the release of the above Information to the extent Indicated and authorized herein.

• I authorize to have my medical records to be released to and/or from the following facility listed below:

_____ Phone:_____ Fax: _____

Information to be released or disclosed (check all that apply):

___ Office Visit: Notes, Consultation Reports, Discharged Reports DOS: _____

___ Laboratory Reports DOS: _____

___ Radiology Reports (Including but not limited to X-Ray, MRI, Scans, U/S, Dexa) DOS: _____

___ EKG's and Holter Reports DOS: _____

___ Complete Chart DOS: _____

Other:_____

Other:_____

Patient Signature:_____ Print Name: _____