PBMC HEALTH | Knowledge of Experts. Compassion of Neighbors.

Agostino Cervone, M.D., F.A.C.S.

General, Robotic, Laparoscopic and Breast Surgery
34 Commerce Drive Suite 1, Riverhead, NY 11901
504B Montauk Highway Center Moriches, NY 11934
496 County Rd 111, Building D, Suite 1, Manorville, NY 11949
Phone: 631-284-9250
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Dear Patient,

Thank you for choosing us to assist in your healthcare needs. Enclosed you will find our new patient packet. Please fill out the paperwork, and bring it with you to your appointment, along with a photo ID & all insurance cards. You will also need to bring any imaging you had done prior to your appointment (ct scan, mammogram, etc.) Please arrive 15 minutes before your scheduled appointment time. This helps to ensure an efficient check-in.

Lastly, please note that appointments not kept, or cancelled with less than 24 hour notice, are subject to a $50 cancellation fee.

If you have any questions or concerns, please feel free to contact us at the above listed number.

Sincerely,

Amy Douglas-Smith
Office & Surgical Coordinator

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PLEASE PRINT ALL INFORMATION CLEARLY

Name	Date of Birth	Sex ( )M ( )F	Social Security #
Marital Status ( ) M ( )S ( ) Divorced	Race	Language	Email Address:
Address:	City	State	Zip Code
Mailing Address (IF DIFFERENT)	City	State	Zip Code
Telephone #:			Cell Phone #:

Primary Care Doctor: _____ Referring Doctor:_____

INSURANCE INFORMATION

Patient Primary Insurance	Identification #	Group #
Policy Holder Name, if other than Patient	Date of Birth	Relationship to Patient
Patient Secondary Insurance	Identification #	Group #
Policy Holder Name, if other than Patient	Date of Birth	Relationship to Patient

EMERGENCY CONTACT INFORMATION

Name	Relationship	Telephone # ( )

EMPLOYER INFORMATION

( ) Currently Employed ( ) Retired ( ) Student

If Employed, Employer Name	Address:	Telephone #: ( )

IS YOUR TREATMENT RELATED TO A WORKER'S COMPENSATION OR NO FAULT CLAIM? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE APPROPRIATE INFORMATION BELOW:

WORKERS COMPENSATION INFORMATION:

Accident or Injury Date: _____ Was this Accident Reported? ☐ Yes or ☐ No
Insurance Company Name: _____ WC Claim #: _____
Address: _____ Policy #: _____
Name of Carrier Contact: _____ Phone #: _____
Employer: _____Phone #: _____
Address: _____

NO FAULT INFORMATION:

Accident or Injury Date: _____ Was this Accident Reported? ☐ Yes or ☐ No
Insurance Company Name: _____ WC Claim #:_____
Address: _____ Policy #: _____
Name of Carrier Contact: _____ Phone #:_____
Employer: _____ Phone #:_____
Address: _____

Patient Signature _____ **Date** _____

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This section for office use.

☐ New patient ☐ Established patient Date: ____/____/_____

REASON FOR VISIT

_____

ADVANCE DIRECTIVES

Date Reviewed: _____ ☐NONE ☐ DNR☐ LIVING WILL ☐DURABLE POWER OF ATTORNEY☐ HC PROXY

MEDICATIONS*(Please PRINT Clearly)*

☐ SEE ATTACHED☐ NO MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

MEDICATION ALLERGIES *(Please PRINT Clearly)*

☐ NO KNOWN ALLERGIES

	REACTION
☐ Accupril (Quinapril)	_____
☐ Acetaminophen	_____
☐ Advil, Motrin (Ibuprofen)	_____
☐ Augmentin (Amoxicillin)	_____
☐ Aspirin	_____
☐ Bactrim (Sulfamethoxazole)	_____
☐ Demerol	_____
☐ Iodine	_____
☐ Latex	_____
☐ Lidocaine	_____

	REACTION
☐Penicillin	_____
☐Percocet (Oxycodone)	_____
☐Sulfa	_____
☐ Valium (Diazepam)	_____
☐ OTHER	
	_____
	_____
	_____
	_____
	_____

FOOD ALLERGIES

☐ NO KNOWN FOOD ALLERGIES

☐ Eggs ☐ Peanuts ☐ Shellfish ☐ Strawberries ☐ Red Dye ☐ IV Contrast Dye

☐ Other _____☐Other_____☐Other _____ ☐Other _____

PAST MEDICAL HISTORY*(Please check all that apply)*

☐ Anemia
☐ Anesthesia Reaction
☐ Angina
☐ Anxiety
☐ Arthritis
☐ Asthma
☐Bleeding Disorder
☐ Blood Clots
☐ Cancer
☐ Cardiac Arrest
☐ Cardiac Arrhythmia
☐ Cardiac Vascular Disease
☐ COPD
☐ Coronary Artery Disease
☐ Crohn's Disease
☐ Dementia
☐ Depression
☐ Diabetes Type I
☐ Diabetes Type II
☐ GERD
☐Headache, Migraine
☐Hepatitis/Liver Disease
☐Hypertension
☐Inflammatory Bowel Disease
☐Malignant Hyperthermia
☐MRSA
☐Osteoporosis
☐Renal Disease
☐ Seizure Disorder
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disease
☐ OTHER
_____
_____
_____
_____
_____
_____
_____

SURGICAL HISTORY(*Please check all that apply)*

☐ Angioplasty
☐ Angioplasty W/ Stent
☐ Appendectomy
☐ Arthroscopy / Knee
☐ Back Surgery
☐ Breast Augmentation
☐ Breast Biopsy
☐Cardiac Pacemaker
☐Carpal Tunnel Release
☐Caesarean Section
☐ Cholecystectomy
☐ Colectomy
☐ D & C (Dilation & Curettage)
☐ Gastric Bypass
☐Hemorhoidectomy
☐ Hernia Repair
☐ Hip Replacement
☐Hysterectomy
☐Knee Replacement
☐Liver Biopsy
☐Mastectomy
☐Nephrectomy
☐Organ Transplant
☐Prostate Biopsy
☐Radiation Therapy
☐TURP (Trans-Urethral Resection)
☐ Thyroidectomy
☐ Tonsillectomy
☐ Valve Replacement
☐ Vasectomy
☐ OTHER
_____
_____
_____
_____
_____

IMMUNIZATIONS

☐ALL IMMUNIZATIONS are up to date

☐ Influenza Vaccine _____ ☐ Tetanus Vaccine _____

☐ Pneumococcal Vaccine _____

PREFERRED PHARMACY:

Name: _____ PHONE #: _____
Address: _____

FAMILY HISTORY

	Mother	Father	Siblings	*(M/P) Grandparent	Children	Yes or No Cause of Death
ADD/ADHD						
Alcoholism						
Allergies						
Alzheimer's Disease						
Arthritis						
Asthma						
Blood Disorder						
Cardiovascular Disease						
Cancer / Type						
Cholelithiasis						
Coronary Artery Disease						
Depression						
Eczema						
Elevated Lipids						
Hearing Impairment						
Hypertension						
Irritable Bowel Disease						
Kidney Disease						
Mental Illness						
Migraines						
Obesity						
Osteoporosis						
Peripheral Vascular Disease						
Renal Disease						
Seizures/Epilepsy						
Stroke						
Thyroid Disorder						

SOCIAL HISTORY

Do you currently use tobacco? ☐NO ☐YES

If **YES**, how many packs per day? _____ How many years smoking? _____

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing ☐ OTHER _____

☐Former Smoker Age started?_____ Age stopped? _____

Do you drink Alcohol?☐NO ☐ YES

Type? _____ Amount? _____ Howoften? _____

☐ Former Drinker Age started?_____ Age stopped? _____

Do you drink caffeine? ☐ NO ☐ YES

Type? _____ Per Day? _____