Welcome

Dear New Patient:

Welcome to the Geriatrics and Medicine Associates (GAMA) at Highland Hospital. We are honored that you will be entrusting us with your medical care. The enclosed packet is designed to help us get to know you and prepare for your first appointment. Please fill out all of the enclosed forms in this packet and send them back to us as soon as possible so that we can schedule your new patient appointment.

- **Registration Form**
  Please fill this out with as much information as possible. Please provide your best contact number so we are able to reach you. Also, it is very important to list your insurance information.
- **History and Physical Form**
  Please fill out as completely as possible.
- **Race and Ethnicity Form**
  This form helps ensure equitable access to healthcare.
- **Patient Permission for discussion of Health Care**
  Please fill in your name, date of birth, if we can contact you at work, if we are allowed to leave voicemails, and who we are allowed to speak with regarding your medical care.
- **Medical Release Form**
  Please fill in your name and address.
  MOST IMPORTANT- please be sure to sign and date the bottom of the release form.

Please return your packet by email, U.S. mail, or fax:

- gamanew@urmc.rochester.edu
- Geriatrics and Medicine Associates (GAMA)
  990 South Avenue, Suite 207
  Rochester, NY 14620
- Fax: (585) 341-8310

GAMA
Geriatrics and Medicine Associates

UR MEDICINE
HIGHLAND HOSPITAL

In order for you to get the most out of your office visits, please read our policies below:

- **Appointments**
  You will need to arrive 15 minutes prior to your scheduled appointment time. If you are running late, please call us as soon as possible. If it is more than 15 minutes, you may be asked to reschedule your appointment.

- **Cancellations**
  Please call the office at (585) 341-6775, at least 24 hours before your scheduled appointment time or you may be charged a $75. fee.

- **No show**
  You may be charged a $75 fee for a no show appointment.

- **Prescription Refills**
  Should be electronically sent from your pharmacy. We require 2 business days to process prescription requests.

- **Medication**
  All medications need to be brought to each of your visits, in order to best meet your health needs. This includes vitamins and non-prescription medications.

- **Telephone Calls**
  Nursing calls related to illness or injury will be returned as soon as possible. Routine calls will be returned within the same business day.

Establishing care with Geriatrics and Medicine Associates will provide you with the following benefits:

- **MyChart**
  An electronic medical record that give you, the patient, easy access to your personal health information all in the same place. This includes appointments, medical history, labs, imaging results, medications, and a fast and easy way to connect with your provider. MyChart allows you and your providers all to be on the same page regarding decisions about your healthcare.

- **CoordinatedCare**
  The patient-centered medical home model provides you with a team to work with you to help prevent illness, as well as manage any chronic medical conditions you may have. This concept also helps connect you with any additional services or providers you need.

Thank you again for joining our practice! We look forward to working with you to attain your best possible health.

GAMA Practices Registration Form

PATIENT'S INFORMATION

DATE _____ PHYSICIAN'S NAME _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME/CELL PHONE # _____ WORK PHONE # _____

CONTACT #1

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME/CELL PHONE # _____ WORK PHONE # _____

CONTACT #2

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME/CELL PHONE # _____ WORK PHONE # _____

PHARMACY NAME _____ PHONE # _____

HEALTH INSURANCE

PRIMARY

INSURANCE COMPANY _____

ID NUMBER _____

GROUP NUMBER _____

SECONDARY

INSURANCE COMPANY _____

ID NUMBER _____

GROUP NUMBER _____

I understand that payment is expected at the time of visit unless previous arrangements have been made. I understand that failure to cancel an appointment with anyone in the office, without 24 hours' notice, may result in a charge for the missed appointment. This charge is not covered by insurance and I will be responsible for the bill. I understand that should my health insurance not reimburse the office for a non-covered service, I will be responsible for the bill. The office will try and notify me if a service is not covered by my insurance. I understand that it is my responsibility to see that proper referral is made from my primary care physician before a specialist is seen.

PATIENT'S SIGNATURE* _____ DATE _____

*If completing this form electronically, typing your name serves as your signature.

GAMA Practices History and Physical

DATE _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

PREVIOUS PHYSICIAN _____ LAST SEEN _____

ADDRESS _____ CITY _____ STATE/ZIP _____

OTHER PHYSICIANS SEEN REGULARLY

NAME _____ SPECIALTY _____ PHONE # _____ LAST SEEN _____

NAME _____ SPECIALTY _____ PHONE # _____ LAST SEEN _____

NAME _____ SPECIALTY _____ PHONE # _____ LAST SEEN _____

NAME _____ SPECIALTY _____ PHONE # _____ LAST SEEN _____

SOCIAL HISTORY

BIRTH PLACE _____ EDUCATION _____

RELIGION _____ EMPLOYMENT _____

MARITAL STATUS _____ # OF CHILDREN/GRANDCHILDREN _____

DOES SOMEONE ELSE DEPEND ON YOU AS A CAREGIVER? _____

ALCOHOL INTAKE _____ SMOKING HISTORY _____

DO YOU ALWAYS USE A SEATBELT? _____ HAVE YOU USED STREET DRUGS? _____

DO YOU HAVE SMOKE DETECTORS? _____ DO YOU EXERCISE REGULARLY? _____

FAMILY HISTORY

	MEDICAL HISTORY	ALIVE	DECEASED
MOTHER:			
FATHER:			
SIBLINGS:			

Self Reported History

NAME _____ DATE OF BIRTH _____

Describe general health compared to others the same age: ____Excellent _ _ Good _ _ Fair _ _ Poor

General health over the past five years _____

_____

Weight: Changes in the past 6 months _____ Past year _____

Describe typical day/hobbies _____

_____

Have you ever been bothered by feeling down, depressed, or hopeless? Yes No

Have you often been bothered by little interest or pleasure in doing things? Yes No

FUNCTIONAL STATUS

Are you able to: (Circle what applies: I= INDEPENDENTLY, A= WITH ASSISTANCE, D= DEPENDENT ON OTHERS FOR HELP)

	I	A	D		I	A	D
GET DRESSED	◉	○	○	DRIVE	◉	○	○
BATHE	◉	○	○	USE PHONE	◉	○	○
USE TOILET	◉	○	○	MANAGE MONEY	◉	○	○
EAT	◉	○	○	PREPARE MEALS	◉	○	○
WALK	◉	○	○	SHOP	◉	○	○

Do you use: _ _walker ____cane _ _commode ____raised toilet seat _ _hospital bed ____wheelchair

Other assistive devices: _____

_____

IMMUNIZATION STATUS

TETANUS _____ PPD _____ INFLUENZA _____ PNUEMOVAX _____

ADVANCED DIRECTIVES

Do you have a health care proxy? Yes No NAME _____

Do you have a living will? Yes No

Health History

NAME _____ DATE OF BIRTH _____

MEDICAL PROBLEMS

SURGERIES

CURRENT MEDICATIONS (Include non-prescription drugs and vitamins)

MEDICATION	DOSE	FREQUENCY

ALLERGIES

Review of Systems (Please check all symptoms you have had in the last 6 months)

GENERAL
___ Insomnia
___ Fatigue
___ Weight Loss/Gain
___ Change in Appetite
___ Cold or Heat Intolerance

SKIN
___ Lesions
___ Wounds
___ Pigmentation Changes
___ Hair/Nail Changes
___ Abnormal Bleeding/Bruising

EYES
___ Vision Changes
___ Pain
___ Cataracts
___ Glaucoma
___ Double Vision
___ Photophobia
___ Infections
___ Glasses/Contacts

EARS
___ Hearing Changes
___ Drainage
___ Ringing
___ Vertigo
___ Infections
___ Hearing Aid (R, L, Both)

NOSE & SINUSES
___ Drainage
___ Bleeding
___ Snoring
___ Pain
___ Post Nasal Drip
___ Infections

MOUTH & THROAT
___ Lesions/Ulcers
___ Hoarseness
___ Voice Changes
___ Difficulty Swallowing/Chewing
___ Sore Throat

BREASTS
___ Lumps/Masses
___ Pain
___ Nipple Discharge
___ Skin Changes

RESPIRATORY
___ Cough
___ Pneumonia
___ Shortness of Breath
___ Wheezing

CARDIOVASCULAR
___ Chest Pain
___ Palpitations
___ Shortness of breath with exertion
___ Ankle Swelling
___ Leg Pain When Walking
___ Stroke or TIA

GI
___ Nausea or Vomiting
___ Indegestion
___ Heart Burn
___ Ulcers
___ Change in Bowel Habits
___ Diarrhea/Constipation
___ Hemorrhoid

GU
___ Pain / Burning with Urination
___ Frequency/Hesitancy
___ Urgency
___ Incontinence
___ Bladder Infection
___ Do you awaken to urinate? How Often? _____

MUSCULOSKELETAL
___ Joint Pain
___ Stiffness
___ Joint Swelling
___ Cramping
___ Muscle Weakness
___ Gait Problems/Falls
___ Fractures? _____

NEURO/PSYCHOSOCIAL
___ Headache
___ Seizures
___ Fainting
___ Coordination Problem
___ Head Injury
___ Memory Issue
___ Anxiety/Depression

REPRODUCTIVE: MALE
___ Penile Discharge
___ Lesions
___ Impotence
___ Inadequate Erections
___ Prostate Problems
___ Cancer

REPRODUCTIVE: FEMALE
___ Vaginal Discharge/Bleeding
___ Lesions
___ Infections
___ Pain with intercourse
___ Abnormal PAP Smear?
___ Taken any hormonal therapy?

Name of person completing this form _____

Relationship to Patient _____

Patient Permission for Discussion of Health Care

DATE _____

NAME _____ DATE OF BIRTH _____

May phone patient at work? Yes No May leave messages on answering machine? Yes No

CONTACT #1

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME/CELL PHONE # _____ WORK PHONE # _____

CONTACT #2

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME/CELL PHONE # _____ WORK PHONE # _____

CONTACT #3

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME/CELL PHONE # _____ WORK PHONE # _____

CONTACT #4

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME/CELL PHONE # _____ WORK PHONE # _____

Ethnicity & Race Form

DATE _____

PATIENT'S NAME _____
FIRST MIDDLE LAST

BIRTH DATE _____ MEDICAL RECORD NUMBER _____
OFFICE USE ONLY

We are asking our patients to share their ethnicity and race. This will help us to know our patients better and improve health care for everyone. Personal information will remain private and confidentia .

Ethnicity: Your ethnicity refers to your background heritage, culture, religion, ancestry or sometimes the country where you were born. For New York State reporting, we are specifically collecting whether or not your ethnicity is Hispanic, Latino, or of Spanish Origin.

Race: Your race is the group(s) that you relate to as having similar features, traits, or birthplace.

What is your ETHNICITY?

☐ **Hispanic** or **Latino** or **Spanish Origin** (If checked, please select up to 4 choices below):

☐ Andalusian	Central American	Dominican	Mexican American	South American
☐ Argentinean	Central American	Ecuadorian	Indian	South American
☐ Asturian	Indian	Gallego	☐ Mexicano	Indian
☐ Belearic Islander	Chicano	Guatemalan	Nicaraguan	Spaniard
☐ Bolivian	Chilean	Honduran	Panamanian	Spanish Basque
☐ Canal Zone	Colombian	La Raza	Paraguayan	Uruguayan
☐ Canarian	Costa Rican	Latin American	Peruvian	Valencian
☐ Castillian	Criollo	Mexican	Puerto Rican	Venezuelan
☐ Catalonian	Cuban	Mexican American	Salvadoran	

☐ **Not Hispanic or Latino or Spanish Origin**
☐ **Patient Refused**

What is your RACE? (You may select up to 4 Races)

☐ **American Indian or Alaska Native**
☐ **Asian** (If checked, please specify from the choices below):

☐ Asian Indian	☐ Chinese	☐ Japanese	☐ Maldivian	☐ Sri Lankan
☐ Bangladeshi	☐ Filipino	☐ Korean	☐ Nepalese	☐ Thai
☐ Bhutanese	☐ Hmong	☐ Laotian	☐ Okinawan	☐ Taiwanese
☐ Burmese	☐ Indonesian	☐ Madagascar	☐ Pakistani	☐ Vietnamese
☐ Cambodian	☐ Iwo Jiman	☐ Malaysian	☐ Singaporean	

☐ **Black or African-American**
☐ **Native Hawaiian or Pacific Islande** (If checked, please specify from the choices below):

☐ Carolinian	☐ Kiribati	☐ Native Hawaiian	☐ Papua New Guinean	☐ Solomon Islander
☐ Chamorro	☐ Kosraean	☐ New Hebrides	☐ Pohnpeian	☐ Tahitian
☐ Chuukese	☐ Mariana Islander	☐ Other Pacific Islander	☐ Polynesian	☐ Tokelauan
☐ Fijian	☐ Marshallese	☐ Pakistani	☐ Saipanese	☐ Tongan
☐ Guamanian	☐ Melanesian	☐ Palauan	☐ Samoan	☐ Yapese
☐ Guamanian or Chamorro	☐ Micronesian			

☐ **White**
☐ **Other**
☐ **Patient Refused**

New Patient Authorization for Release of Medical & Behavioral Health Information

NAME _____ DATE OF BIRTH _____

This Authorization allows URMC & Affiliates to RECEIVE copies of your record from (or discuss your information with) the provider/person/facility below.

NAME OF PROVIDER or FACULTY _____

ADDRESS _____ CITY _____ STATE/ZIP _____

PHONE # (Include Area Code) _____ FAX # (Include Area Code) _____

Purpose for this request: Health Care

Type of Records Requested:

- 2-3 years of pertinent progress notes
- All immunizations
- Medical imaging
- Most recent EKG
- Most recent labwork
- Any/all procedures (e.g., colonoscopy)
- History & physical
- Other_____

Authorization Valid For: (Check one)

☐ This request only

☐ One year from the date of this authorization OR _____ (insert date).
This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request is for medical records of any future treatment of the type described above until: _____

I understand that:

- My right to health care treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of the form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information requires additional authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requestor is not the patient): _____

Patients' Responsibilities

At Highland Hospital, we believe patients and families are partners in ensuring that the best possible care is provided in a healthful, safe environment. We count on you to participate in your care in the following ways:

- To the best of their knowledge, provide accurate and complete information about their present symptoms, past illnesses, hospitalizations, medications and other matters relating to their health.
- Provide upon admission a copy of their health care proxy or any other advance directives or power of attorney forms, if they have them.
- Report any changes in their condition or anything that appears unsafe to their nurse or doctor.
- Ask questions if they do not clearly understand the proposed plan of care and what is expected of them.
- Follow the treatment plan that the patient and their doctor have developed. This may include following the instructions of nurses and other health care staff who are involved in their care.

Accept the consequences if they do not follow the treatment plan.

- Understand that requests for changes of provider or other staff based on race, ethnicity, religion, disability, age, sexual orientation or gender identity will not be honored. Requests for provider or staff changes based on gender will be considered on a case by case basis and only based on extenuating circumstances.
- Keep appointments. When they are unable to do so for any reason, notify the office appointment center in advance
- Provide accurate insurance information and promptly pay balances not covered by their insurance.
- Treat other patients and staff with consideration and respect.
- Be considerate of the rights of other patients and the hospital staff by assisting with the control of noise and the number of visitors to the hospital.
- Be respectful of the property of other persons and of the hospital.

Know that the following items and behaviors are not allowed at the hospital:

- Alcoholic beverages
- Weapons
- Smoking
- Illegal drugs
- Tobacco
- Electronic Cigarettes and emerging tobacco and nicotine products
- Any pictures, video, or audio in a patient care setting without expressed permission from staff
- Disruptive or violent behaviors

Additional Patient Rights:

You will be free from financial or other exploitation and have access to legal entities for appropriate representation self-help services and advocacy support services.

If you have questions, suggestions, or concerns or if you need help resolving a problem and would rather not share it with your nurse or another member of your health care team, please call Patient and Family Relations at (585) 341-9673 or send an email to PatientRelationsHH@urmc.rochester.edu. If something is bothering you, you can talk to us without being afraid that we will be upset with you. You will continue to get excellent care. If you are not satisfied with the response you get from us, you have the right to contact the New York State Department of Health. (We can provide that phone number.) And if our concerns cannot be resolved through the hospital or Department of Health, you may contact the Joint Commission onlinc at https://www.jointcommission.org/rcport a complaint.aspx.