third space medical

be young and healthy from the inside out

Dr. Tatiana Sharahy, MD

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Ridgewood NJ 07450
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Third Space Medical

Name: _____

What are your most important expectations as our patient? _____

_____

Medical History: Please check the column that applies to each question. Feel free to leave blank any questions you wish to discuss with the doctor.

Condition	Does not apply	*Myself*	Siblings	Parents	Grand-parents
1. Heart Disease					
2. Cancer					
3. Diabetes					
4. High blood pressure					
5. Arthritis					
6. Liver disease (hepatitis, cirrhosis, etc.)					
7. Psychiatric illness (depression, anxiety, psychotic disorders, etc.)					
8. Autoimmune disease (lupus, rheumatoid arthritis, etc.)					
9. Endocrine disorders (thyroid, adrenal, pituitary)					
10. Neurological disorders (stroke, seizures, Parkinson's, Alzheimer's, multiple sclerosis, etc.)					
11.Lung diseases (asthma, emphysema, bronchitis, etc.)					
12. Kidney diseases (stones, infections, cysts, etc.)					
13. Stomach/Esophagus disorders (reflux, stricture, ulcers, etc.)					
14. Bowel diseases (malabsorption , lactose intolerance, diverticulitis, Chron's colitis, etc.)					
15. Bladder disease					
16. Substance abuse (alcohol, prescription, recreational drugs, tobacco)					
17. Weight control problems					
18. Osteoporosis/ Weak bones					
19. Migraine headaches					
20. Anemia					
21. HIV/AIDS					
22. Allergies					

1. Please provide any additional information you wish to share with the doctor: _____
   _____
   _____

2. Please list any surgical procedures you have had (including plastic surgery), along with the approximate date: _____
   _____

3. Please list any diagnostic procedures you have had (MRI's, blood work) along with the approximate date: __
   _____
   _____

4. Please list any history of trauma that you experienced (car accidents, head injuries, broken bones, etc.) : ____
   _____
   _____

5. Please list any drug allergies you have, along with the reaction you experienced: _____
   _____

6. Have you ever had a blood transfusion? If so, please list when and for what reason:_____
   _____

Please list all the medications (prescription and/or over-the-counter) you are currently taking and for what condition:

Medication	For what Condition?	Dose (mg):	Times per day:

Please list all supplements (vitamins, herbs, nutritional supplements) you are currently taking and for what condition or you can copy labels and send it with questionnaire:

Supplement	For what Condition?	Dose (mg):	Times per day:

Notes:

Name_____DOB_____

Please indicate if any of the following symptoms/conditions pertain to you now or in the past.
Please indicate with a "P" if the condition is Persistent or "O" of the condition is Occasional:

Digestive Tract
__ Diarrhea
__ Constipation
__ Bloated Feeling
__ Belching
__ Passing Gas
__ Stomach Pains

Ears, Mouth, Nose, Throat
__ Itchy Ears
__ Ear Aches
__ Ear Infections
__ Drainage from ear
__ Ringing in ears
__ Hearing loss
__ Chronic Coughing
__ Gagging
__ Often clear throat
__ Sore throat
__ Swollen tongue/lips
__ Canker sores
__ Stuffy nose
__ Sinus problems
__ Hay fever
__ Sneezing attacks
__ Excessive mucous

Emotions
__ Mood swings
__ Anxiety, fear
__ Irritability, anger
__ Depression
__ Aggressiveness
__ Nervousness

Energy & Activity
__ Fatigue
__ Sluggishness
__ Apathy
__ Hyperactivity
__ Restlessness
__ Lethargy

Eyes
__ Watery eyes
__ Itchy eyes
__ Swollen eyelids
__ Sticky eyelids
__ Dark circles
__ Blurred Vision

Head
__ Headaches
__ Faintness
__ Dizziness
__ Insomnia

Lungs
__ Chest congestion
__ Asthma, bronchitis
__ Shortness of breath
__ Difficulty breathing

Mind
__ Poor memory
__ Confusion
__ Poor concentration
__ Stuttering/ stammering
__ Learning disabilities
__ Seizures

Musculoskeletal
__ Pain in joints
__ Arthritis
__ Stiffness
__ Limited movement
__ Aches in muscles
__ Feeling of muscle weakness
__ Neck Pain
__Lower Back Pain
__ Knee Pain
__ Numbness _____
(location)
__ Sciatica

Skin
__ Acne
__ Hives, rashes
__ Hair loss
__ Flushing/hot flashes
__ Excessive sweating
__ Dandruff

Weight
__ Binge eating
__ Cravings
__ Excessive Weight
__ Compulsive eating
__ Water retention
__ Underweight

Other Medical History

__ Irregular/rapid heartbeat
__ Chest pains
__ Frequent illness
__ Urgent urination
__ Sexual dysfunction
__ High blood pressure
__ Diabetes
__ Metabolic syndrome/ Insulin resistance
__ Menopausal symptoms
__ Premenstrual syndrome
__ Thyroid dysfunction
__ Genital itch
__ Bladder/ Urinary Infection
__ Cancer_____
__ Gout
__ PCOS
__ Miscarriage
__ Food Allergies
__ Balance Issues

Other:

For Use Physician Only: ☐ Mercury ☐ Immuno ☐ MicroNutrient ☐ Amino Acids

Comments: _____

Tatiana Sharahy, MD
1144 East Ridgewood Avenue, Ridgewood, NJ 07450
Office: (201)444-0020 Fax: (201)444-0026

Name: _____ Date: _____

1. Address: _____

   _____

2. Phone Numbers (Please circle preferred contact number):
   a. Home: _____
   b. Office: _____
   c. Cell: _____

3. Confidential Email (to send your confidential medical information):
   _____
   May we use this Email to send information on promotions or newsletters? _____(Y/N)
4. Confidential Fax (to send your confidential medical information):
   _____

5. Sex: _____Female _____Male 6. Height:_____

7. Weight:
   a. Current Weight: _____
   b. Weight one year ago: _____
   c. Highest adult weight: _____
   d. Lowest adult weight: _____
   e. Lowest weight held for more than 2 years:_____
   f. Most comfortable weight: _____

8. Frame Size: _____Small _____Medium _____Large

9. Date of Birth: _____/_____/_____

10. Personal Physician Name & Number:_____

11. Pharmacy Phone Number: _____

12. Marital Status: *Circle One* Single Married/Partnered Divorced Widowed

13. Number of Children: _____

14. Who lives in your household? _____

14. How did you hear about our office? (name of friend/advertisement) _____-

    _____

15. Please list any known allergies (food/medications/environmental, etc)_____

Pure Anti-Aging Medical Center
1144 E. Ridgewood Avenue
Ridgewood, NJ 07450
Phone: 201-444-0020 Fax: 201-444-0026

CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENT

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/ or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to PURE ANTI-AGING MEDICAL CENTER all medical benefits and/ or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charge regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release any medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/ or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/ or employee health care plan any claim, chose in action, or any right I may have to such insurance and/ or employee health care benefits coverage under any applicable insurance policies and/ or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic to pursue such claim, chose in action or right against my insurers and/ or employee health care plan, including if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I have read and full understand this agreement.

MEDICARE/MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information give in applying for payment under Title XVII and. Or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female patients only):

By my signature of this for, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period: _____

Signature of Insured/ Guardian:_____

Date: _____

Witness: _____

PURE ANTI-AGING MEDICAL CENTER
1144 EAST RIDGEWOOD AVENUE
RIDGEWOOD, NJ 07450
TEL: 201-444-0020 FAX: 201-444-0026

PRIVACY NOTICE TO PATIENTS

Congress passed the Health Insurance Portability and Accountability and Accountability Act (HIPPA) in August of 1996. Title II of the Act gives the health care consumer specific privacy protection rights. We are required to provide our Notice of Privacy Practices (NPP) by the Department of Health and Human Services (HHS). We are committed to treating and using protected health information about you responsibly.

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE DISCLOSED AND HOW YOU MAY HAVE ACCESS TO YOUR "PROTECTED HEALTH INFORMATION (PHI). PLEASE REVIEW THIS INFORMATION CAREFULLY. YOU ARE REQUESTED TO SIGN THIS FORM BELOW AFTER READING IT.

This office may use your PHI in providing health care to you. We may use your PHI during office visits or when providing health care in a hospital setting. Under federal law, we may disclose your PHI to you or when we forward your medical information to that physician. We can also disclose your PHI for payment purposes (such as your insurance provider, employer, Medicare or other parties responsible for providing you with health insurance coverage) so that we may be reimbursed for our services. We may also use your PHI for health care operations (quality assurance and medical chart reviews). We may disclose your PHI when required by the secretary of the US Department of Health and Human Services.

Unless disclosure is required under federal or state law, or certain other exceptions including law enforcement, we are prohibited from disclosing your PHI without your authorization. We may use your PHI in accordance with the specific requirements of the HIPPA rules without needing to obtain your authorization if the information is:

1. Required by law
2. Required for public health purposes
3. Required disclosure about victims of abuse, neglect, or domestic violence
4. Required by a health oversight agency for activities authorized by law
5. Required by the course of any judicial or administrative proceeding
6. Required by a law enforcement purpose to a law enforcement official
7. Required by a coroner, medical examiner, or armed forces if you are a member
8. Required by an organ procurement organization for research
9. If disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public

In the event we wish to disclose your PHI to any other entity not listed above, we are required to obtain your authorization. For example, if you participate in a research study, we would require your written authorization before releasing your PHI to an outside facility. If you provide us with authorization you can revoke it any time by sending us written revocation.

You can access, copy, inspect, and request in writing to amend your medical information that we maintain. We will prepare a summary or explanation of your health information for a fee, and charge you a fee for copies, and staff time. We can provide you with an accounting of all disclosures for treatment, payment or healthcare operations.

If you have a dispute with our practice regarding our use of your PHI or any disclosure, please contact one of our front desk personnel to file a dispute or you may directly contact the Secretary of Health and Human Services.
Finally, please be advised that you have the right to request restrictions on certain use and disclosure of your PHI to carry out treatment, payment, healthcare operations or disclosure to a family member, relative, or a friend. However, we are not required by federal law to agree to your requested restriction. If you request a copy of your PHI, you have the right to request that we send it to an alternative location. This notice will be posted in our office, and a copy will be provided to you.

Please sign below to acknowledge receipt of the Physician Privacy Notice for the office of Pure Anti-Aging Medical Center

Print Name: _____ Signature: _____ Date: _____