MKR Medical PC
Marc Rybstein, MD Cardiology
828 Utica Av. Brooklyn, New York 11203 tel. 718-303-0851 fax: 1800-801-3525

Patient Registration:

Patient Last Name: _____ First Name: _____ M.I_____ DOB: _____

SS# _____ **Sex:** Male □ Female □ **Marital status:** Single□ Married □ Widowed □ Divorced □

Address_____City_____State ____ Zip _____

Home #_____Cell #_____Work #_____

Email Address: _____

Emergency Contact:

Name: _____ Tel: _____Relation: _____

Insurance Information:

Primary Cardholder_____ Insurance Name_____ID#_____

DOB of Cardholder_____ Relationship to Patient: Self/Spouse/Child

Referral Information:

How did you learn about our office? _____

Primary care physician/referring physician_____

Pharmacy Name & Address:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to MKR Medical PC for services rendered.
I understand that I am responsible for all charges regardless of insurance coverage.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize MKR MEDICAL PC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A copy of these assignments shall be valid as the original.

Patient/Guardian: _____ Date: ____/_____/_____
(Signature)

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Pre-existing Medical Conditions: _____
1. Reason of visit: _____

#	QUESTIONS?	PREGUNTAS?	YES (SI)	NO
1	Do you have **chest discomfort**?	Tiene Asma?		
2	Do you have **shortness of breath**?	Falta Respiracion?		
3	Do you **palpitations**?	EstaTosiendo?		
4	Do you have cough/congestion?	EstaCongestionada?		
5	Do you have wheezing?	Silvidoen el Pecho?		
6	Do you have asthma?	Dolor de Pecho?		
7	Do you have headaches?	Dolor de Cabeza?		
8	Do you snore?	UstedRonca?		
9	Do you gasp for air while sleeping?	Falta de airemientrasduermes?		
10	Do you sneeze a lot/often?	Estornudamucho o con frecuencia?		
11	Do you have itchy/watery eyes symptoms?	Le pican los ojos o estanlagrimosos?		
12	Do you have post nasal drip?	Molestiaen la garganta?		
13	Do you have runny nose?	Narizhumeda o mucosidad?		
14	Do you have **diabetes**?	Tiene Diabetes?		
15	Do you have **High Blood Pressure**?	Tiene Presion Arterial Alta?		
16	Do you have cold feelings in your arms/legs?	Sensiacion de frioenbrazos/piernes?		
17	Do you feel fatigue often?	Se sientecansado con frecuencia?		
18	Do you have excessive daytime sleepiness?	Le da suenoexesivodurante el dia?		
19	Do you smoke? If yes, how many cigarettes a day? _____	UstedFuma? CuantosCigarrillosdiarios? _____		
20	Any surgical history? If yes, what kind and when/year_____ _____	AlgunaCirugia? Cual? _____ _____		
21	What medications are you taking now? List them. _____ _____ _____ _____	CualesMedicinaestatomandoactualmente? _____ _____ _____		
22	Any other health problems _____ _____	Algunaotracondicion Medica?		
23	What is your height? _____ What is your current weight? _____	Cual es suestatura? _____ Cual es su peso? _____		

Patient Signature: _____ **Date: _____**
Name and Signature of Parent/Guardian _____