

SHERRELL J. ASTON, M.D., F.A.C.S., P.C.
728 PARK AVENUE
NEW YORK, NEW YORK 10021
212-249-6000

Today's Date: _____ Age: _____ Birth Date: _____

Mrs. ___ Miss. ___ Ms. ___ Mr. ___ Dr. ___ Social Security Number: _____

Patient Name (As It Appears On Drivers License) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Local Address in N.Y. Visitor: _____

Email Address _____

Marital Status: _____ Name of Spouse: _____

Next of Kin: _____ Relationship: _____

Person Referred By: _____ Relationship: _____

Internet Site: _____

City/State: _____

Person Responsible for Bill: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Phone: _____

Please be advised that Dr. Aston does not participate with any type of insurance companies or plans including but not limited to Worker's Compensation or Medicare. I have read and understand the above statement:

Signature: _____

Print Name: _____ Date: _____

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DO YOU HAVE A HISTORY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

Heart Disease: ___ Seizures: ___ Bleeding Problems: ___ Fainting Spells ___ Varicose Veins: ___ Phlebitis: ___ Asthma: ___
Thrombosis: ___ Diabetes: ___ Anemia: ___ Enlarged Glands: ___ Blood Pressure ___ Cancer: ___ Thyroid: ___ Paralysis: ___
Problems with Nose or Sinus ___ Difficulty breathing right or left side: ___ Hepatitis ___ HIV/AIDS ___
Problems with Eyes: ___ Disease ___ Injury ___ Impaired Vision ___ Sleep Apnea: ___ Sleep Study: ___
List any decreased sensations you have experienced throughout your body: _____
List any preexisting medical conditions _____
Are you a Smoker? _____ If So How Much _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Penicillin ___ Sulfa Drugs ___ Aspirin ___ Keflex ___ Codeine ___ Morphine ___ Valium ___ Demerol ___ Tetanus ___
Antibiotic Ointment ___ Antitoxin ___ Latex Allergy ___ Serums ___ Mycin ___ Adhesive Tape ___ Epinephrine ___

ANY OTHER MEDICATION ALLERGIES:

SURGICAL PROCEDURES: Please list year and performing surgeon; including cosmetic surgery

HAVE YOU RECEIVED HOSPITAL MEDICAL ATTENTION; UNDER WHAT CIRCUMSTANCE?

MEDICATIONS:

Please list all medications; include name, dosage and frequency

Sedatives _____ Premarin _____ Tranquilizers _____ Blood Pressure _____
Sleeping Pills _____ Other Drugs _____

HERBAL AND HOLISTIC MEDICATIONS:

Please list all over-the-counter products you use including vitamins & minerals _____

FAMILY HISTORY

Diabetes _____ Heart Disease _____ Bleeding Disorders _____

Cancer _____ Sleeping Problems/ Sleep Apnea _____ Other _____

Have you had a physical within the last 12 months? ___ Height _____ Weight _____

Name of Primary Care Physician: _____

Phone number: _____

Name and number of Cardiologist: _____

Phone number: _____

Name and number of Pulmonologist: _____

Phone number: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that Sherrell J. Aston MD, PC has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

- I have received Sherrell J. Aston MD, PC's Privacy Notice
- I understand that I am responsible for the fees in advance as Dr. Aston does not participate with any type of insurance

Patient Signature: _____ **Date:** _____

OFFICE USE ONLY Does patient have a copy of the Privacy Notice? Yes No