# Christopher E. Beney, M.D., P.C.

**1149 Lincoln Ave~Lockport, NY~14094~ 716-433-2674~ Fax:716-433-2677**

Chad Shepherd, DNP, FNP~ Karey Schmelz RPA-C~ Shannon McCrory, CPNP-BC~
Lindsey Thering, RPA-C~ Christopher Pease, RPA-C~ Emma Harrington, FNP-BC~
Mary Schriever, RPA-C~ Aaron Mruk, FNP~ Peter Kelley, FNP


## Adult Registration

Patient Name: _____ D.O.B._____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Cell Phone Carrier:_____

Email: _____

Preferred Method Of Contact: Home Phone Cell Phone Email

Date of your last physical with your previous medical provider: _____

Race: White/ African American/ Hispanic/ American Indian/Asian/ Other

Ethnicity: Hispanic or Latino/ Not Hispanic or Latino

Employer: _____ Occupation: _____

Marital Status: Single/ Married/ Divorced/ Widowed

Spouse Name: _____

Spouse Phone Number: _____ Spouse D.O.B. _____

### Emergency Contact Other Than Spouse

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

**PLEASE BE PREPARED TO PRESENT YOUR INSURANCE AT EVERY VISIT!**

Name of Insurance Company: _____

Insurance ID Number: _____

# Annual Comprehensive Health Questionnaire

**The following questionnaire will assist your physician in formulating a comprehensive medical assessment for you at your annual wellness exam. It is essential that you provide interval changes in your medical and family situation as well as details of any current health concerns to allow your physician to be more effective in assessing your present and future health concerns. Of course, if there have been no changes since your last visit, you may simply write "No Change." Your responses will be reviewed with you by your provider during your evaluation.**

## Section 1: Present Health Status:

1. How do you assess your overall health status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. What would you say your overall health status is over the past few years?
   ☐ Stable ☐ Improving ☐ Declining
3. How content are you with your general health?
   ☐ Very Content ☐ Somewhat Content ☐ Disappointed in present health.
4. Do you see a dentist routinely? ☐ Yes ☐ No When was your last visit?_____
5. When was your last Eye Exam? _____ Who is your Eye Doctor? _____
6. Do you wear glasses contacts? ☐ Yes ☐ No
7. Do you have hearing aids? ☐ Yes ☐ No
8. Do you have an Advanced Care Plan or Directive?
   ☐ Yes ☐ No (If Yes please bring a copy with you to your next appointment.)
   Would you like to discuss an Advanced Directive Today? ☐ Yes ☐ No

## Section 2: Past Medical History

1. Have you had any significant medical illnesses since your last Physical? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
2. Have you been in the hospital or emergency room since your last Physical? ☐ Yes ☐ No
   If yes, please list with dates: _____
   _____
   _____

3. Have you had any surgical procedures or diagnostic testing since your last Physical?

☐ Yes ☐ No

If yes, please list with dates: _____

_____

4. Please list your food and drug allergies: _____

_____

5. Have you had any vaccinations since your last physical? ☐ Yes ☐ No

If yes, please list with dates: _____

_____

6. Do you see any other doctors (specialists)? ☐ Yes ☐ No

If yes, please list:_____

_____

7. Please list any past surgeries you have had: _____

_____

**Section 3: Family History**

**For the list below please indicate which blood relatives have had complications with the following problems. Blood relatives include Mother, Father, Grandparents, Siblings, Aunts, Uncles, and First Cousins. The information you offer will enable us to best maintain your health.**

Anemia/Other Blood Disease (Specify which)_____ Asthma _____

Mental Handicap _____ Drug Problem_____

Alcoholism_____ Cancer (Specify Type) _____

AIDS/HIV_____ Cystic Fibrosis _____

Muscular Dystrophy _____ Tuberculosis _____

Arthritis _____ Epilepsy/Seizures _____

Heart Disease _____ High Blood Pressure _____

Kidney/Urine Problems _____ Cholesterol Problems _____

Smoker's _____ Diabetes_____

Migraines _____ SIDS (Sudden Infant Death Syndrome) _____

Birth Defects _____ Mental Health Concerns _____

Other Chronic Illnesses (Please specify) _____

**Section 4: Social History**

1. What is your Marital Status? _____ What is your current occupation? _____
2. Are you sexually active? ☐ Yes ☐ No Self described Gender orientation?_____
3. Number of children? ☐ Boys ☐ Girls

   Besides spouse and children, any one else living in your home?

   Explain: _____
4. Do you smoke tobacco? ☐ Yes ☐ No How many per day? _____

   For how many years? _____ Are you ready to quit? _____
5. Are you exposed to secondhand smoke? ☐ Yes ☐ No
6. Do you drink alcohol? ☐ Yes ☐ No
7. Do you use illegal drugs or abuse prescription medications? ☐ Yes ☐ No

   If yes, please explain: _____
8. Have you felt the need to cut down on drinking alcohol or drug use? ☐ Yes ☐ No

   Have you felt annoyed by others criticizing your drinking or drug use? ☐ Yes ☐ No

   Have you ever felt guilty about drinking or drug use? ☐ Yes ☐ No

   Have you ever felt you needed a drink first thing in the morning? ☐ Yes ☐ No
9. Do you follow a health diet? ☐ Yes ☐ No Specific Diet? _____
10. Do you exercise? ☐ Yes ☐ No How Often? _____
11. Do you consume caffeinated beverages? ☐ Yes ☐ No How much? _____
12. Do you feel you have an adequate social life? ☐ Yes ☐ No
13. Do you feel you have the resources necessary (i.e. food, housing, transportation, etc) to meet your daily needs? ☐ Yes ☐ No
14. Do you have difficulty sleeping at night? ☐ Yes ☐ No
15. In the last few weeks have you felt nervous, anxious or on edge? ☐ Yes ☐ No
16. In the last few weeks have you been unable to stop or control worrying about things? ☐ Yes ☐ No
17. In the last few weeks have you felt down, depressed, or hopeless? ☐ Yes ☐ No

    If so, please explain: _____

    _____

    _____

    _____

## Medications

**PLEASE BE AWARE:** It is our office policy that we do not prescribe controlled medications. If you are on a controlled medication, you must currently be established with a Physician who can prescribe and maintain for you them. (Pain specialist, Psychiatrist, Etc…)

Current Medication List:

| Medication Name | Strength | How Many Per Day |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| 11. | | |
| 12. | | |
| 13. | | |
| 14. | | |
| 15. | | |

**Name and Address of your preferred pharmacy: _____**

**Phone Number of pharmacy: _____**

**Signature: _____**

**** Please note, if this page is not signed your new patient paperwork will not be entered. ****

**Christopher E. Beney, M.D., P.C.**

**Permission to release Medical Information**

I authorize information regarding my care and treatment to be released as set forth on this form to the following person/persons:

I understand that: This authorization may include disclosure of information relating to my medical records, I have the right to revoke this authorization at any time by writing to the provider listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditional upon my authorization of this disclosure.

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Patient Name: _____ Date of Birth: _____

Responsible Party: _____

Signature:_____ Date: _____

# Christopher E. Beney, M.D., P.C

## Financial Policy

***Insurance:** We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits- including eligibility, covered benefits, and medically necessary procedures is your responsibility, please contact customer service at your insurance company for questions you may have regarding your coverage. You are responsible for any charges not covered by your plan. We do not accept Worker's Compensation.

***Proof Of Insurance:** All Patients must complete and/or update our Patient Information form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will automatically be billed to you.

***Co-Payments and Deductibles:** All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, coinsurances, deductibles, and non-covered services.

***Claim Submission:** We will submit your insurance claims to assist you in a way reasonable to help get your claim paid. Your insurance company may need to you supply information directly to them. It is your responsibility to comply with their request in a timely manner. Texas insurance law requires your insurance company to provide timely payment. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. We are not a party to your insurance contract.

***Referrals:** If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical care facility care, etc. It is your responsibility to inform the office of this requirement prior to referral. We require 72 hours notice to facilitate a referral request and cannot issue retroactive referrals.

***Out-Of-Network Care/Self Pay:** Please be aware that you have an option to seek care from Physicians even though they are not participating in your network. In this situation, your out-of-pocket expense will be greater. As a courtesy to our out-of-network patients, we will file your insurance claim if desired, and offer a 10% reduction from our usual fees. This benefit also applies to individuals without insurance.

I certify that I, and/or my dependent(s) have insurance and assign directly to Dr.Christopher Beney all insurance benefits, if any, otherwise payable to be for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I also acknowledge the use of my health care information but the above physician may be disclosed to insurance companies and their agents for the purpose of obtaining payment for services and determining benefits payable to related services.

Patient Name: _____ Date Of Birth: _____

Signature: _____ Date: _____

**Christopher E. Beney, M.D., P.C.**
**Patient Contract**

By Signing below, I state that I understand that, as a patient of Dr.Beney's Practice, I am held to the following:

I will follow the direction of the Providers in the practice, whether it is told to me personally by them or thru a staff member.
I will come to the office for a complete physical every year or as prescribed by my Provider.
I will follow thru on referrals my Provider sends me to in a timely manner.
I will get testing done that my Provider prescribes for me in a timely manner, or at the direction of the provider.
I understand that it is my responsibility to arrange a time to have consultations or testing done.
I understand that the Providers will give me prescriptions to have preventative services done (for example colonoscopy, mammogram, etc.) and I will have these tests done in a timely manner, unless I have refused to have these done and it is documented in my electronic medical record.
When possible, I will contact the office prior to going to an Emergency Room or Urgent Care Center to see if the office can accommodate my acute problem.
If I have an emergency, I will go to the closest Emergency Room, or the Emergency Department the provider directs me to.
I will follow the posted policies of the practice.
I understand that the Practice will contact me ONCE if I am delinquent in following thru with referrals or testing.
I understand that there is a $50.00 charge for any missed appointments without 24hrs advanced notice.
I understand that if I miss 3 appointments without calling the office to cancel I will be discharged from the practice.
I understand that if I am delinquent, I risk being discharged from the practice.
If discharged, I understand that I will be given 30 days to find another Doctor, in accordance to New York State Law.

Signature: _____ Date: _____

**Christopher E. Beney, M.D., P.C.**
**Late Arrival Policy**

Christopher E. Beney, M.D., P.C. would appreciate all patients to be on time for their scheduled appointments. We do understand that things come up and are sympathetic to this. In the event of a patient coming to their appointment 10 minutes late or more after their scheduled appointment time, this would be deemed as "Late".

"Late" is the term we use when a patient arrives later than their scheduled appointment time. Unfortunately being late to an appointment is an inconvenience to those patients present at their scheduled time, and those who need access to medical care in a timely manner. In the event that you arrive "Late" to your appointment please note that you may be asked to reschedule.

A failure to present at the time of a scheduled appointment will be recorded in your medical chart as "Late". You may be sent a letter alerting you to the fact that you have been late for a scheduled appointment. This is a warning letter. A copy of that letter will be placed in your medical record. After 6 "Late" appointments are recorded in the chart, that will result in dismissal from the practice.

By signing below I acknowledge and read Christopher E. Beney, M.D., P.C.'s Late Policy.

Name (Please Print): _____

Signature:_____ Date: _____

When you have finished filling out this form, click the button below. Your PDF viewer (Adobe Acrobat/Reader) will open a new email addressed to our office with this completed form attached.

Submit Completed Form by Email

Button not working? Save this completed PDF and contact our office to schedule your appointment.
716-433-2674