

Fiasconaro & Fiasconaro M.D. , P.C.

7502,Colonial Road
Bay Ridge,Brooklyn
718.748.8484
718.630.5770
www.drfrasconaro.com

Making an Appointment at Fiasconaro & Fiasconaro, M.D. , P.C.

Office Hours

Monday - Dr. Gary Fiasconaro 12PM to 6PM
Tuesday - Pregnant Patients Only 12PM to 6PM
Wednesday - New Patients Only 12PM to 6PM
Thursday - Dr. Santo Fiasconaro 12PM to 6PM

When You Call for Your First Appointment

Please provide our staff with the following information:

- Full Name
- Telephone numbers (home, work and cellular)
- Name of your referring physician (if you have one)
- Insurance information (please indicate if HMO or PPO plan)

Financial information

What Insurances do you accept?

If your Insurance company is not listed, you may check with our Office Staff (Monday through Thursday Noon-6PM) Some Insurance carriers listed here have special requirements, you may check with our Office Staff for these restrictions.

BlueChoice	Cigna
GHI	HIP
Magnacare	Medicare NY Hospital Health Plan
Oxford*	PHS
United Healthcare	1199

*** PLEASE CALL OXFORD TO REGISTER ONE DOCTOR AS YOUR OB/GYN**
FOR DR.GARY FIASCONARO REFERENCE # : P926280
FOR DR.SANTO FIASCONARO REFERENCE # : P2103376

PLEASE TYPE YOUR PATIENT ID # HERE:

If you are a Patient and do not know your Patient ID #, please call the office at 748-8484 or 630-5770 Monday through Thursday 11AM-6PM and ask any Staff member for your ID #.

Fiasconaro & Fiasconaro, M.D. P.C.

New Patient --- First Visit

COPAY _____

CASH _____

First Name: _____ Last name _____
Address: _____
City/State: Zip _____
Date Of Birth: _____ / _____ / _____ Referred By: _____
Social Security #: _____ - _____ - _____
Home Phone (_____) _____
CELL Phone: (_____) _____
Allergy: If NO ALLERGIES write NONE _____

Occupation: _____

Work Phone & EXTN: (_____) _____

Primary Insurance: _____

IF YOU ARE INSURED AT YOUR EMPLOYMENT, THEN THIS IS YOUR PRIMARY INSURANCE

IF INSURANCE IS NOT BY YOUR EMPLOYER, PLEASE SUPPLY THE FOLLOWING:

Insured's Name: _____

Address: if different from above _____

City/State: Zip _____

Insured's Date of Birth _____

Insured's Employer: _____

Secondary Coverage _____

I authorize Fiasconaro & Fiasconaro M.D. P.C., to furnish information to my insurance carrier(s) concerning my illness and treatments and assign benefits directly to them. I am responsible for any amount not covered. I also understand that all information about my past, present & future conditions is considered PROTECTED HEALTH INFORMATION. I will allow you to discuss my condition only with _____

Signature Of Patient _____

PLEASE, MAKE SURE TO BRING YOUR CURRENT INSURANCE CARD TO EACH VISIT

YOUR AGE: _____ REASON FOR VISIT: _____
LAST PERIOD: _____ LAST PAP: _____

GENERAL

HIGH BLOOD PRESSURE	YES	NO
DIABETES	YES	NO
ANEMIA	YES	NO
LOSS-OF WEIGHT	YES	NO
CHANGE IN BOWELS	YES	NO
RECTAL BLEEDING	YES	NO
BACK PAIN	YES	NO
SEIZURES	YES	NO
CLOTS in LEG or LUNGS	YES	NO
DEPRESSION	YES	NO
ANXIETY	YES	NO

MEDICATIONS _____

HEART & LUNGS

PALPITATIONS	YES	NO
MITRAL VALVE PROLAPSE	YES	NO
SHORTNESS OF BREATH	YES	NO
SMOKER	YES	NO
ASTHMATIC	YES	NO

MEDICATIONS _____

BREAST

BREAST PAIN	YES	NO
BREAST LUMP	YES	NO
BREAST DISCHARGE	YES	NO

EYES

GLAUCOMA	YES	NO
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HEAD & NECK

MIGRANES	YES	NO
NOSE BLEEDS	YES	NO
THYROID PROBLEMS	YES	NO

MEDICATIONS _____

OTHER: _____

PLEASE FILL THIS PAGE ONLY IF PREGNANT.

FIASCONARO & FIASCONAO,MD., P.C.

NAME: _____

INFORMATION NECESSARY FOR OBSTETRICAL REGISTRATION

Your Marital Status: M / S / D **Race:** _____ **Height:** _____

Father of baby's Name	
Father's Age and Race	
Father's Occupation:	

If you'll be unmarried at delivery, please request Paternity papers from this Office for the baby's Birth certificate

FAMILY HISTORY:

Medical Problems:	
Genetic or hereditary: (i.e.) Down's Syndrome, Spina Bifida, Tay Sachs, Sickle Cell or Thalassemia	

If you or the baby's father are JEWISH, have either of you been tested for Tay Sachs? If yes, bring those results.
If you or the baby's father are African-American, have either of you been tested for Sickle Cell? If yes, bring results.

YOUR MEDICAL HISTORY : Please advise us of any changes not already on your records.

Recent Medical Problems:	
Current Medications:	Including ASPIRIN, LOVENOX, VITAMINS, INSULIN
Medical Doctor:	Phone#
Recent Surgeries:	
Allergies:	

OBSTETRICAL HISTORY: (please include all Pregnancies including all miscarriages or abortions)

YEAR	HOSPITAL	TERM/ # WEEKSEARLY/ LATE Include # of HOURS in labor	Vaginal /C- Sect	Baby's Sex	Baby's Weight	Any problems during or after Delivery for Mom or Baby?

*******FOR DOCTORS USE-ONLY*******

- HIV, FE++, FOLIC ACID,PRETERM LABOR REVIEWED AT CONSULT
- PSYCHO-SOCIAL, NUTRITIONAL & DOMESTIC VIOLENCE REVIEWED AT CONSULT
- DRUG USE, ETOH, SMOKING REVIEWED AT CONSULT

- INFERTILITY MULTIPLE GESTATION
- Hx OF PTL, INCOMPOTENT CERVIX, or CERCLAGE
- Hx OF PIH Hx OF GDM INSULIN PREGESTATION DIABETIC

HIGH RISK FACTORS NOTED: _____

ORDER: 1 ST VISIT BLOODS; SONOGRAM at AK / WEB / MM, GENETIC COUNSELLING

G ___ P ___ BY ___ S/G PACKET: YES / NO ENTERED BY _____