Doruk Erkan, M.D.

Barbara Volcker Center for Women & Rheumatic Disease – Hospital for Special Surgery
535 East 70th Street, New York, N.Y. 10021
Phone 212 774 2291 – Fax 212 774 2374

Patient Registration Form

Today's Date: _____

Name: _____ Date of Birth: _____ Sex: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Fax: _____

Occupation/Employer: _____

Office Address: _____

Phone: _____ Fax: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Address: _____

Phone: _____ Fax: _____

INSURANCE INFORMATION:

Please check your insurance policy for a waiting period before coverage or pre-existing clauses. If your coverage is contingent on a second opinion or pre-authorization or pre-admission, it is your responsibility to inform us.

Primary Insurance		Secondary Insurance	
Address:		Address:	
City/State/Zip:		City/State/Zip	
Policy Holder		Policy Holder	
Insured ID		Insured ID	
Number:	DOB:	Number:	DOB:
Group Number/Name		Group Number/Name	
If W/C, provide date of Accident			

Assignment Release of Information Statement: I certify that the information given by me is correct and hereby authorize the release of information related to my medical care as requested by government agencies and / or insurance companies. I hereby assign benefits to Dr. Erkan and authorize payment directly to Dr. Erkan for services rendered. Medicare request that payment of authorized Medicare benefits be made on my behalf to Dr. Erkan.

Signature: _____ Date: _____

BARBARA VOLCKER CENTER FOR WOMEN AND RHEUMATIC DISEASE

NEW PATIENT QUESTIONNAIRE

Patient Name:_____

Referring Physician: ☐ Check if there is none

Physician's Name:_____ Specialty:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone No.:_____ Fax:_____

Primary Care Physician: ☐ Check if there is none

Physician's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone No.:_____ Fax:_____

Other Physicians:

Physician's Name:_____ Specialty:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone No.:_____ Fax:_____

Physician's Name:_____ Specialty:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone No.:_____ Fax:_____

Physician's Name:_____ Specialty:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone No.:_____ Fax:_____

BARBARA VOLCKER CENTER FOR WOMEN AND RHEUMATIC DISEASE

NEW PATIENT QUESTIONNAIRE

Name:_____

Date form filled out:_____Date of your birth:_____

1. Drugs (include doses) you take now:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

2. Drugs to which you are allergic:

_____ _____
_____ _____

3. Please outline in chronological order the symptoms that have led to your visit here, beginning with the very first symptom you relate to this illness (please use blank pages if necessary):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

4. Have you had any other major illnesses, injuries, or hospitalizations? When?

_____
_____
_____
_____
_____
_____
_____

5. Please tell me about your family's health.

Are your grandparents living? If not, what caused their deaths? What major illnesses do or did they have?

Mother's mother_____

Mother's father_____

Father's mother_____

Father's father_____

Are your parents living? If not, what caused their deaths? What major illnesses do or did they have?

Mother_____

Father_____

Your brothers and sisters? Do they have any major illnesses?

_____

_____

Your children? Do they have any major illnesses?

_____

_____

6. Please tell me some personal facts:

Are you married? _____no ___yes

Have you ever been? _____no____yes

Are you from or have you lived in a foreign land? _____no____yes

What kind of work do you do?_____

7. Please tell me about your habits and any other symptoms *(please underline as needed):*

A. Do you smoke? _____no____yes
   If yes, how much? _____
   If you stopped, when?_____

B. Do you drink alcohol? _____no____yes
   If yes, how much? _____
   If you stopped, when?_____

C. Do you have recurrent headaches, light-headed spells, or fainting spells? Have you had a head injury? _____no____yes

D. Do you have any problems with your eyes? Inflammation (red eye), dryness of the eyes, change in vision? _____no____yes

E. Do you have any problems with your ears? Balance problems? Hearing problems? _____no____yes

F. Do you have any problems with your nose? Recurrent nose bleeds? Sores? Sinusitis? _____no___yes

G. Do you have any problems with your mouth or teeth? Sores? Bleeding? Unusual dryness? Swelling of your cheeks or glands? _____no____yes

H. Do your lymph glands swell? Where? _____ _____no____yes

I. Have you had a problem with your thyroid gland? _____no____yes

J. Any recent change in your weight? _____no____yes

K. Have you had skin rashes, change in texture of your skin, change in skin color, change in hair color? _____no____yes

L. Do you have any problems when you go in the sun? _____no____yes

M. Do you have any breathing problems or chest pain? _____no____yes
N. Do you have coughing? Phlegm? _____no____yes
Wheezing or other sounds from your chest? _____no____yes
O. Have you ever been told of a heart problem? Abnormal rhythm? Murmur? Take blood pressure or other heart medicines? _____no____yes
P. Do your fingers, toes, or other parts of your body change color in the cold? _____no____yes
Q. Have you had any problem with your liver, gall bladder, stomach, or intestines? Do you get stomach pains? Constipation? Diarrhea? Have you ever vomited blood or had blood in your bowel movements? Have you ever had jaundice (skin turns yellow)? _____no____yes
R. Do you have any problem with your urine? Blood in your urine? Protein (albumin)? Infections? Pain in your kidneys or back? Kidney stones? Do you lose urine spontaneously? Has your urine ever stopped up? Have you ever had venereal disease? _____no____yes
T. Have you ever had a seizure, stroke, weakness on one side of your body, persisting numbness or tingling anywhere? _____no____yes
U. Have you ever had hallucination, depression or other mental Problems? Problem with thinking or confusion? _____no____yes

V. For men: have you had a PSA test? _____no____yes

Y. For women: How old were you when you had your first period? _____
Have your periods stopped? _____no____yes
Have you had problems with your periods? _____no____yes
Have you had a female surgery of any kind? _____no____yes
Have you had a recent Pap smear? _____no____yes
Have you had a recent mammogram? _____no____yes

Z. Have you had a bone mineral density test? _____no____yes
Have you been tested for HIV (AIDS)? _____no____yes

Thank you for filling out this form. I look forward to meeting you.

Doruk Erkan, MD