

PLEASE PRINT CLEARLY AND ANSWER ALL QUESTIONS

Date \_\_\_\_\_ Home Phone(\_\_\_\_) \_\_\_\_\_  
Social Security # \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Mr./Mrs. \_\_\_\_\_ Marital \_\_\_\_\_  
Ms./Miss \_\_\_\_\_ Birthdate \_\_\_\_\_ Status \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Business Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

**Referred By:**

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Primary Care Doctor:**

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**OB/GYN:**

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**In Case of Emergency (someone not living with you):**

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship \_\_\_\_\_

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Primary Insurance \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Subscriber \_\_\_\_\_ ID# \_\_\_\_\_ Group/Policy# \_\_\_\_\_  
Other Insurance \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Subscriber \_\_\_\_\_ ID# \_\_\_\_\_ DOB \_\_\_\_\_ Group/Policy# \_\_\_\_\_

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**DR.OSTROW DOES NOT ACCEPT NO-FAULT OR WORKERS COMPENSATION CASES OR  
MEDICAID. THIS HAS BEEN FULLY EXPLAINED TO ME. I AGREE TO BE FULLY  
RESPONSIBLE FOR PAYMENT OF ALL FEES THAT MY MAJOR MEDICAL INSURANCE DOES  
NOT COVER.**

**SIGNATURE** \_\_\_\_\_

**PATIENT QUESTIONNAIRE**

PATIENT'S NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX \_\_\_\_\_ S.M.W.D. \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ TEL. NO. \_\_\_\_\_  
 INSURANCE \_\_\_\_\_ REFERRED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_

**INSTRUCTIONS** PUT  IN THOSE BOXES APPLICABLE TO YOU AND IN THE "YES" OR "NO" SPACE. IF LINES ARE PROVIDED WRITE IN YOUR ANSWER.

**FAMILY HISTORY**

|                          | FATHER | MOTHER | BROTHER |   |   |   | SISTER |   |   |   | SPOUSE | CHILDREN |   |   |   |   |   |
|--------------------------|--------|--------|---------|---|---|---|--------|---|---|---|--------|----------|---|---|---|---|---|
|                          |        |        | 1       | 2 | 3 | 4 | 1      | 2 | 3 | 4 |        | 1        | 2 | 3 | 4 | 5 | 6 |
| AGE (IF LIVING)          |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| HEALTH (G) GOOD (B) BAD  |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| CANCER                   |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| TUBERCULOSIS             |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| DIABETES                 |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| HEART TROUBLE            |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| HIGH BLOOD PRESSURE      |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| STROKE                   |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| EPILEPSY                 |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| NERVOUSE BREAKDOWN       |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| ASTHMA, HIVES, HAY FEVER |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| BLOOD DISEASE            |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| AGE (AT DEATH)           |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |
| CAUSE OF DEATH           |        |        |         |   |   |   |        |   |   |   |        |          |   |   |   |   |   |

**PERSONAL HISTORY**

| HAVE YOU EVER HAD...  | NO | YES | HAVE YOU EVER HAD...   | NO | YES | HAVE YOU EVER HAD...  | NO                    | YES |
|---|----|-----|--|----|-----|---|-----------------------|-----|
| MIGRAINE HEADACHES  |    |     | <input type="checkbox"/> RHEUMATIC FEVER <input type="checkbox"/> HEART DISEASE                      |    |     | ANY <input type="checkbox"/> BROKEN <input type="checkbox"/> CRACKED BONES                              |                       |     |
| FREQUENT <input type="checkbox"/> COLDS <input type="checkbox"/> STREP THROAT |    |     | <input type="checkbox"/> HIGH <input type="checkbox"/> LOW BLOOD PRESSURE                            |    |     | RECURRENT DISLOCATIONS  |                       |     |
| CHRONIC FATIGUE   |    |     | DIABETES   |    |     | <input type="checkbox"/> CONCUSSION <input type="checkbox"/> HEAD INJURY                                |                       |     |
| <input type="checkbox"/> HAY FEVER <input type="checkbox"/> ASTHMA            |    |     | <input type="checkbox"/> ULCER <input type="checkbox"/> GASTRITIS                                    |    |     | EVER BEEN KNOCKED UNCONSCIOUS?  |                       |     |
| <input type="checkbox"/> HIVES <input type="checkbox"/> ECZEMA                |    |     | APPENDICITIS   |    |     | <input type="checkbox"/> FOOD <input type="checkbox"/> CHEMICAL <input type="checkbox"/> DRUG POISONING |                       |     |
| <input type="checkbox"/> PSORIASIS <input type="checkbox"/> SHINGLES          |    |     | GALL BLADDER DISEASE   |    |     | EXPLAIN:  |                       |     |
| <input type="checkbox"/> POLIO <input type="checkbox"/> MENINGITIS            |    |     | <input type="checkbox"/> IRRITABLE BOWEL <input type="checkbox"/> COLITIS                            |    |     |   |                       |     |
| <input type="checkbox"/> PNEUMONIA <input type="checkbox"/> PLEURISY          |    |     | <input type="checkbox"/> PARASITES <input type="checkbox"/> WORMS                                    |    |     | ANY OTHER DISEASE?  |                       |     |
| TUBERCULOSIS  |    |     | CANCER   |    |     | EXPLAIN:  |                       |     |
| EPILEPSY  |    |     | NERVOUS BREAKDOWN  |    |     |   |                       |     |
| <input type="checkbox"/> KIDNEY DISEASE <input type="checkbox"/> STONES       |    |     | <input type="checkbox"/> ARTHRITIS <input type="checkbox"/> RHEUMATISM                               |    |     | AGE   | HOW OLD DO YOU FEEL?  |     |
| <input type="checkbox"/> GONORRHEA <input type="checkbox"/> SYPHILIS          |    |     | <input type="checkbox"/> NEURITIS <input type="checkbox"/> NEURALGIA                                 |    |     | HEIGHT  | HAVE YOU LOST HEIGHT? |     |
| <input type="checkbox"/> JAUNDICE <input type="checkbox"/> HEPATITIS          |    |     | <input type="checkbox"/> BURSITIS <input type="checkbox"/> LUMBAGO <input type="checkbox"/> SCIATICA |    |     | WEIGHT  | IDEAL BODY WEIGHT?    |     |
| ANEMIA  |    |     | WHIPLASH WHEN?   |    |     |   |                       |     |

**ALLERGIES**

| ARE YOU ALLERGIC TO...  | NO | YES | ARE YOU ALLERGIC TO... | NO | YES | ARE YOU ALLERGIC TO...  | NO | YES |
|---|----|-----|------------------------|----|-----|---|----|-----|
| <input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULFA DRUGS                            |    |     | ANY OTHER DRUGS        |    |     | ANY FOODS   |    |     |
| <input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> MORPHINE |    |     | EXPLAIN                |    |     | EXPLAIN   |    |     |
| <input type="checkbox"/> MYCINS <input type="checkbox"/> OTHER ANTIBIOTICS                          |    |     |                        |    |     |   |    |     |
| <input type="checkbox"/> TETANUS <input type="checkbox"/> ANTITOXIN <input type="checkbox"/> SERUMS |    |     | ADHESIVE TAPE          |    |     | <input type="checkbox"/> NAIL POLISH <input type="checkbox"/> OTHER COSMETICS |    |     |

**SURGERY**

| HAVE YOU HAD REMOVED... | NO | YES | HAVE YOU HAD REMOVED...   | NO | YES | HAVE YOU HAD REMOVED...           | NO | YES |
|-------------------------|----|-----|---|----|-----|-----------------------------------|----|-----|
| TONSILS                 |    |     | <input type="checkbox"/> OVARY <input type="checkbox"/> OVARIES |    |     | HAD HERNIA REPAIRED               |    |     |
| APPENDIX                |    |     | HEMORRHOIDS   |    |     | HAD ANY OTHER OPERATIONS          |    |     |
| GALL BLADDER            |    |     | EVER HAVE A TRANSFUSION   |    |     | BEEN HOSPITALIZED FOR ANY ILLNESS |    |     |
| UTERUS                  |    |     | <input type="checkbox"/> BLOOD <input type="checkbox"/> PLASMA  |    |     | EXPLAIN                           |    |     |

**X-RAYS**

| X-RAYS  | NO | YES | DATE | AB NORMAL RESULTS | X-RAYS  | NO | YES | DATE | AB NORMAL RESULTS |
|---|----|-----|------|-------------------|---|----|-----|------|-------------------|
| EVER HAVE X-RAYS OF...  |    |     |      |                   | COLONOSCOPY   |    |     |      |                   |
| CHEST   |    |     |      |                   | ENDOSCOPY   |    |     |      |                   |
| <input type="checkbox"/> STOMACH <input type="checkbox"/> COLON |    |     |      |                   | STRESS TEST   |    |     |      |                   |
| GALL BLADDER  |    |     |      |                   | PROSTATE / RECTAL   |    |     |      |                   |
| BACK  |    |     |      |                   | GYN EXAM  |    |     |      |                   |
| EXTREMITIES   |    |     |      |                   | <input type="checkbox"/> MRI <input type="checkbox"/> CT SCAN |    |     |      |                   |
| MAMMOGRAM   |    |     |      |                   |   |    |     |      |                   |

### SYSTEMS

| DO YOU NOW HAVE OR HAVE YOU EVER HAD...  | NO | YES | DO YOU NOW HAVE OR HAVE YOU EVER HAD...   | NO | YES |
|--|----|-----|---|----|-----|
| ANY <input type="checkbox"/> EYE DISEASE <input type="checkbox"/> EYE INJURY <input type="checkbox"/> IMPAIRED SIGHT                           |    |     | COUGH <input type="checkbox"/> FREQUENT <input type="checkbox"/> CHRONIC                                  |    |     |
| ANY <input type="checkbox"/> EAR DISEASE <input type="checkbox"/> EAR INJURY <input type="checkbox"/> IMPAIRED HEARING                         |    |     | <input type="checkbox"/> CHEST PAIN <input type="checkbox"/> ANGINA                                       |    |     |
| ANY TROUBLE WITH <input type="checkbox"/> NOSE <input type="checkbox"/> SINUSES <input type="checkbox"/> MOUTH <input type="checkbox"/> THROAT |    |     | <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> FLUTTERING HEART                           |    |     |
| SEASONAL ALLERGY   |    |     | SWELLING OF: <input type="checkbox"/> HANDS <input type="checkbox"/> FEET <input type="checkbox"/> ANKLES |    |     |
| HEADACHES: <input type="checkbox"/> FREQUENT <input type="checkbox"/> SEVERE   |    |     | SHORTNESS OF BREATH: <input type="checkbox"/> EXERTION <input type="checkbox"/> NIGHT                     |    |     |
| FAININESS OR DIZZINESS   |    |     | NIGHT SWEATS  |    |     |
| CLENCHING OR GRINDING TEETH  |    |     | <input type="checkbox"/> FREQUENT URINATION <input type="checkbox"/> EXCESSIVE THIRST                     |    |     |
| BLEEDING GUMS  |    |     | DROWSY AFTER MEALS?   |    |     |
| FREQUENT TIREDNESS OR FATIGUE  |    |     | GET SHAKY INSIDE IF HUNGRY?   |    |     |
| TROUBLE REMEMBERING THINGS   |    |     | CRAVE: <input type="checkbox"/> CANDY <input type="checkbox"/> CHOCOLATE <input type="checkbox"/> OTHER   |    |     |
| DECREASED SEXUAL INTEREST OR PLEASURE  |    |     | HAVE TO URINATE AT NIGHT?   |    |     |
| THYROID: <input type="checkbox"/> OVERACTIVE <input type="checkbox"/> UNDERACTIVE <input type="checkbox"/> ENLARGED                            |    |     | PROSTATE TROUBLE  |    |     |
| COLDS HANDS OR FEET  |    |     | <input type="checkbox"/> NARROWED URINARY STREAM <input type="checkbox"/> HESITATION                      |    |     |
| SKIN DISEASE   |    |     | <input type="checkbox"/> BLADDER PROBLEMS <input type="checkbox"/> INCONTINENCE                           |    |     |
| INDIGESTION OR HEARTBURN   |    |     | STIFF JOINTS IN THE MORNING   |    |     |
| EXCESSIVE BLOATING OR BELCHING   |    |     | LEG PAIN WHEN WALKING   |    |     |
| <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> DIARRHEA  |    |     | MUSCLE TWITCHING OR CRAMPS  |    |     |
| <input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> RECTAL BLEEDING  |    |     | NUMBNESS OR TINGLING  |    |     |
| <input type="checkbox"/> ANY CHANGE IN APPETITE? <input type="checkbox"/> EATING HABITS?   |    |     | DIFFICULTY FULLY TURNING HEAD   |    |     |
| RECENT WEIGHT GAIN OR LOSS?  |    |     | DIFFICULTY SITTING, BENDING, OR LIFTING   |    |     |
| VEGETARIAN? <input type="checkbox"/> OVO <input type="checkbox"/> LACTO <input type="checkbox"/> FISH  |    |     | UNCOORDINATION (DROP OR BUMP INTO THINGS)   |    |     |

### IMMUNIZATION - EKG

| HAVE YOU HAD...                            | NO | YES | HAVE YOU HAD...                   | NO | YES  |
|--|----|-----|-----------------------------------|----|------|
| SMALLPOX VACCINATION (WITHIN LAST 7 YEARS) |    |     | POLIO SHOTS (WITHIN LAST 2 YEARS) |    |      |
| TETANUS SHOT (NOT ANTITOXIN)               |    |     | AN ELECTROCARDIOGRAM              |    | WHEN |

### HABITS

| DO YOU...   | NO | YES | DO YOU USE...  | NEVER | OCC. | FREQ | DAILY |
|---|----|-----|--|-------|------|------|-------|
| EXERCISE ADEQUATELY   |    |     | LAXATIVES  |       |      |      |       |
| HOW?  |    |     | VITAMINS   |       |      |      |       |
| AWAKEN RESTED   |    |     | BIRTH CONTROL PILLS  |       |      |      |       |
| SLEEP WELL  |    |     | TRANQUILIZERS  |       |      |      |       |
| AVERAGE 8 HOURS SLEEP (PER NIGHT)   |    |     | SLEEPING PILLS, ETC.   |       |      |      |       |
| DO YOU REMEMBER YOUR DREAMS?  |    |     | ASPIRINS, ETC.   |       |      |      |       |
| HAVE REGULAR BOWEL MOVEMENTS?   |    |     | CORTISONE  |       |      |      |       |
| SEX - ENTIRELY SATISFACTORY   |    |     | ALCOHOLIC BEVERAGES  |       |      |      |       |
| LIKE YOUR WORK (    HOURS PER DAY) <input type="checkbox"/> INDOORS <input type="checkbox"/> OUTDOORS       |    |     | COFFEE (    CUPS PER DAY)  |       |      |      |       |
| WATCH TELEVISION (    HOUSE PER DAY)  |    |     | TOBACCO: <input type="checkbox"/> CIGARETTES (    PKGS PER DAY)  |       |      |      |       |
| READ (    HOURS PER DAY)  |    |     | <input type="checkbox"/> CIGARS <input type="checkbox"/> PIPE <input type="checkbox"/> CHEWING TOBACCO   |       |      |      |       |
| HAVE A VACATION (    WEEKS PER YEAR)  |    |     | <input type="checkbox"/> SNUFF   |       |      |      |       |
| HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM   |    |     | APPETITE DEPRESSANTS   |       |      |      |       |
| HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE   |    |     | THYROID MEDICATION: <input type="checkbox"/> NO <input type="checkbox"/> YES, IN PAST <input type="checkbox"/> NONE NOW <input type="checkbox"/> NOW ON    GR. DAILY               |       |      |      |       |
| RECREATION: DO YOU PARTICIPATE IN SPORTS OR HAVE HOBBIES WHICH GIVE YOU RELAXATION AT LEAST 3 HOURS A WEEK. |    |     | HAVE YOU EVER TAKEN...   |       |      |      |       |
|   |    |     | <input type="checkbox"/> INSULIN <input type="checkbox"/> TABLETS FOR DIABETES <input type="checkbox"/> HORMONE SHOTS <input type="checkbox"/> TABLETS <input type="checkbox"/> NO |       |      |      |       |

### WOMEN ONLY

| MENSTRUAL HISTORY                             | NO        | YES        | MENSTRUAL HISTORY  | NO        | YES        |
|---|-----------|------------|--|-----------|------------|
| AGE AT ONSET                                  |           |            | ARE YOU REGULAR: <input type="checkbox"/> HEAVY <input type="checkbox"/> MEDIUM <input type="checkbox"/> LIGHT |           |            |
| USUAL DURATION OF PERIOD            DAYS      |           |            | DO YOU HAVE <input type="checkbox"/> TENSION <input type="checkbox"/> DEPRESSION BEFORE PERIOD                 |           |            |
| CYCLE (START TO START)            DAYS        |           |            | DO YOU HAVE <input type="checkbox"/> CRAMPS <input type="checkbox"/> PAIN WITH PERIOD                          |           |            |
| DATE OF LAST PERIOD                           |           |            | DO YOU HAVE HOT FLASHES  |           |            |
| <b>PREGNANCIES</b>                            | <b>NO</b> | <b>YES</b> |  | <b>NO</b> | <b>YES</b> |
| CHILDREN BORN ALIVE            (HOW MANY    ) |           |            | STILL BORN            (HOW MANY    )   |           |            |
| CESAREAN SECTIONS            (HOW MANY    )   |           |            | MISCARRIAGES            (HOW MANY    )   |           |            |
| PREMATURES            (HOW MANY    )          |           |            | ANY COMPLICATIONS  |           |            |

### EMOTIONS

| ARE YOU OFTEN... | NO | YES | ARE YOU OFTEN...            | NO | YES |
|------------------|----|-----|-----------------------------|----|-----|
| DEPRESSED        |    |     | JUMPY                       |    |     |
| ANXIOUS          |    |     | JITTERY                     |    |     |
| IRRITABLE        |    |     | IS CONCENTRATION DIFFICULT? |    |     |

## **Ostrow & Associates**

Osteopathic Musculoskeletal Medicine  
Osteopathic Diagnosis and Treatment  
625 Madison Avenue-Suite 10-A  
New York, New York 10022  
Tel: (212) 838 8265 Fax: (212) 752 5140

### **RE: X-Ray Duplication Policy**

In the course of treatment in our office, it may be necessary for you to have X-rays taken. In accordance with New York State legal precedence, the original films become part of the permanent medical records and are the property of this office. The information that the X-Rays provide in the form of a report, or duplicates, can be made available to you. New York State Public Health Policy Regulations allow physicians to maintain the original X-Ray copies except in cases of emergencies. Duplication fees will be based on the number and size of films that are copied.

Signature \_\_\_\_\_

**Gary L. Ostrow D.O., P.C.**  
**625 Madison Avenue, Ste. 10-A**  
**New York, NY 10022**  
**(212) 838 8265**

**THIS NOTIFICATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights you have.

Minerva Cabralda, Privacy Officer, is in charge of privacy matters at our office. You can contact her at 212 838 8265 if you desire further information, or have any questions or concerns.

**Use and disclosure of protected information.**

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you or written authorization by you. For example, if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS).

Federal law provides that we may use your medical information to obtain payment for our services without specific notice to you, or written authorization by you. Such as under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered.

Federal law provides that we may use medical information for health care operations without further specific notice to you, or written authorization by you. Such as, our accountants may see your name, dates of treatment and procedure codes during audits of our books. Also, we may use your information for financial services, quality assurance, risk reduction, and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. required by law;
2. required for public health purposes;
3. required by law to report child abuse;
4. where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct
5. required by law in judicial or administrative proceedings;
6. required for law enforcement purposes by a law enforcement official;
7. required by a coroner or medical examiner;
8. permitted by law to a funeral director;
9. permitted by law for organ donation purposes;
10. permitted by law to avert a serious threat of health or safety;
11. permitted by law and required by military authorities if you are a member of armed forces of the United States;

New York State law provided additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space for this is provided below.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

**Rights that you have.**

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law [or for research or public health purposes after being de-identified or limited to remove personally identifiable information] or disclosures made before April 14, 2003.

If you receive this notice electronically, you have the right to obtain a paper copy from our office.

**Obligations that we have.**

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to

Minerva Cabralda  
Privacy Officer  
625 Madison Avenue Ste.10-A  
New York, NY 10022  
Tel. (212) 838 8265

No retaliatory action will be taken against you for any complaint you may make.

I have received a paper copy of this notice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

I make the following special requests for confidential communications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Gary L. Ostrow D.O., P.C.  
625 Madison Avenue STE 10-A  
New York, NY 10022

Request for Restrictions/Changes in the way we communicate with patient  
Re: Confirmation of appointments

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_

In what way do we communicate with you regarding confirmation of appointments?

Can we call you at your residence? Yes No

Can we call you at work? Yes No

Can we leave messages with your family members on  
your answering machine? Yes No

Can we leave messages on your machine at work? Yes No

Do you have any specific instructions regarding the way we communicate with you?

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Signature of patient/guardian \_\_\_\_\_ Date: \_\_\_\_\_