Todd A. Schneiderman, MD FACS

Name*:_____ Date of Birth*:_____

Home Address*:_____ City*:_____ State*:_____ Zip*:_____

Home Phone*:_____ Email*:_____

Cell Phone #*:_____ Marital Status: Married:☐ Single:☐ Widowed:☐ Divorced:☐

Occupation: _____

Employer's Name*:_____ Work Phone #: _____

Employer Address*:_____City*:_____ State*:_____ Zip*:_____

Social Security #: XXX XX _____ Emergency Phone*:_____

How did you learn about our practice: _____

Pharmacy: _____

Parent / Guardian / Spouse Information

Name*:_____ Date of Birth*:_____

Home Address*:_____ City*:_____ State*:_____ Zip*:_____
(If different)

Home Phone*:_____ Work Phone #: _____ SS#: _____-_____-_____
(If different)

Employer's Name*:_____

Employer Address*:_____ City:_____ State:_____ Zip:_____

Primary Insurance:

Insurance Name*: _____ ID#*:_____

Insured's Name*:_____ Insured Date of Birth*:_____ Group #: _____

Secondary Insurance:

Insurance Name*: _____ ID#*:_____

Insured's Name*:_____ Group #: _____

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Todd A Schneiderman, MD, FACS, for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information to determine these benefits payable for related services.

_____ _____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Todd A. Schneiderman, MD, FACS, for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Date of Appointment: _____

Name: _____ Gender: _____ Age: _____

Reason for visit

What *brings* you to the office today?

Who referred you?

Who's your primary doctor?

Allergies

Do you have any allergies? ☐ Yes ☐ No

Name Reaction

Height: **Weight:**

Current Medications

Are you currently taking any blood thinners?
☐ Yes ☐ No
What medications are you currently taking?

Name Name

Name Name

Name Name

Past Medical History (Please circle)

- ☐ Allergic rhinitis
- ☐ Anemia
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cancer
- ☐ Circulatory system disorder
- ☐ Depression
- ☐ Diabetes
- ☐ Headache
- ☐ Hearing Loss
- ☐ Heartburn
- ☐ High blood pressure (hypertension)
- ☐ High cholesterol
- ☐ Hypothyroid
- ☐ Mitral valve disorder
- ☐ Obstructive sleep apnea
- ☐ Sinusitis
- ☐ Stroke
- ☐ Other

Hospitalizations & Surgeries

1. Reason Date

2. Reason Date

3. Reason Date

Family History (Please circle)

- ☐ Allergic rhinitis
- ☐ Anemia
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cancer
- ☐ Circulatory system disorder
- ☐ Depression
- ☐ Diabetes
- ☐ Headache
- ☐ Hearing Loss
- ☐ Heartburn
- ☐ High blood pressure (hypertension)
- ☐ High cholesterol
- ☐ Hypothyroid
- ☐ Mitral valve disorder
- ☐ Obstructive sleep apnea
- ☐ Sinusitis
- ☐ Stroke
- ☐ Other

Women Only

Are you pregnant?
☐ Yes ☐ No

Have you ever smoked?
☐ Yes ☐ No # of years
Do you smoke now?
☐ Yes ☐ No # packs/day
How much alcohol do you drink per week? # drinks/week
Do you live?
☐ alone ☐ with spouse ☐ with children ☐ with friends

Review of System (Please circle)

General: ☐ fevers, ☐ fatigue, ☐ sleep problems, ☐ weight gain, ☐ weight loss, ☐ speech delay

Eyes: ☐ eye pain, ☐ vision loss, ☐ excessive tears, ☐ irritation

Ears / Nose / Throat: ☐ ear pain or discharge, ☐ tinnitus, ☐ decreased hearing, ☐ nasal obstruction or discharge, ☐ nosebleeds, ☐ sore throat, ☐ hoarseness, ☐ difficulty swallowing, ☐ snoring, ☐ sleep apnea, ☐ dizziness

Cardiovascular: ☐ chest pains, ☐ palpitations, ☐ shortness of breath

Respiratory: ☐ cough, ☐ excessive sputum, ☐ coughing blood, ☐ wheezing

Gastrointestinal: ☐ nausea, ☐ vomiting, ☐ diarrhea

Genitourinary: ☐ pain with urination, ☐ bed wetting, ☐ blood with urination

Musculoskeletal: ☐ back pain, ☐ joint pain, ☐ muscle cramps

Skin: ☐ rash, ☐ itching, ☐ ulcers/growths, ☐ excess scarring, ☐ bleeding problem, ☐ suspicious lesions

Neurologic: ☐ headache, ☐ weakness, ☐ paresthesias, ☐ seizures, ☐ syncope, ☐ tremors

Psychiatric: ☐ depression, ☐ memory loss, ☐ mental disturbance, ☐ suicidal ideation, ☐ hallucinations

Endocrine: ☐ cold intolerance, ☐ heat intolerance, ☐ excessive thirst, ☐ excessive urination

Heme / Lymphatic: ☐ abnormal bruising, ☐ bleeding, ☐ enlarged lymph nodes

Allergic / Immunologic: ☐ urticaria, ☐ hay fever, ☐ persistent infections, ☐ HIV exposure