

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 #: _____ - _____ - _____ 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:

Name of Insurance: _____ ID#: _____
Insured's Name: _____ Insured Date of Birth: _____ Group #: _____

Secondary Insurance:

Name of Insurance: _____ 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?

Current Medications

Are you currently taking any blood thinners?

Yes No

What medications are you currently taking?

Name

Name

Name

Allergies

Do you have any allergies? Yes No

Name

Reaction

Height:

Weight:

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

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

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

Hospitalizations & Surgeries

1. Reason _____ Date _____

2. Reason _____ Date _____

3. Reason _____ Date _____

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

COVID-19 - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weakened or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

| | Yes | No |
|--|-----|----|
| Do you have a fever or above normal temperature? | | — |
| Have you experienced shortness of breath or had trouble breathing? | | |
| Do you have a cough? | | |
| Do you have a runny nose? | | |
| Have you recently lost or had a reduction in your sense of smell? | | |
| Do you have a sore throat? | | |
| Have you been in contact with someone who has tested positive for COVID-19? | — | |
| Have you tested positive for COVID-19? | | |
| Have you been tested for COVID-19 and are awaiting results? | | |
| Have you traveled outside of the US in the past 14 days? If so, where? | | |

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Name: _____

Date: _____

We are using special consideration with the coronavirus pandemic.

Let us know if you have had any fever, cough, shortness of breath, facial pain, sore throat, muscle aches, change in smell/taste.

Exposure to anyone with CORONAVIRUS.

For the safety of all staff and patients, we will have the least contact possible. There will be a morning telemedicine visit then an afternoon office visit for the exam.

We want to reduce the time spent in person for everyone.

Everyone in the office has to wear a mask, NO EXCEPTIONS, keep the MASKS on all the time until the Doctor tells you otherwise.

Only the patient is allowed in the office. Exceptions only when medically necessary: interpreters, caregivers giving ambulation assistance, or patient is a minor-only 1 visitor.

If you are accompanied by a visitor they stay in the car.

Once the patient reaches the parking lot, give us a call, wait in the car until we say to come in.

Go straight to the exam room, no sitting in the waiting room.

Please come on time, or we may need to reschedule. We can take a credit card number for the copay. Cash and check still preferred. Please use your own pen for checks.

The time in the office is greatly reduced for safety.

Use the bathroom at home before you come.