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*: ______ (If different) City*: ______ State*: ______ Zip*: ______

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

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

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
Have you been vaccinated?		
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 or within 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.

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 your 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.