

Patient information

Patient Name:	Date of Visit:	
Date of Birth:	Social Security #:	
Street Address:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
City, State, Zip:	Weight:	Height:
Home telephone #:	Employer:	
Work #:	Occupation:	
Cell #:	Marital Status/Spouse Name:	
e-mail address:	Pharmacy Phone #:	

May we leave messages on your answering machine? Yes No

***(note: the representative from our office will never leave any personal health information on an answering machine)

I authorize Dr. Schaeffer/Dr. Ephrat/Medical Staff to discuss/release my medical record to:
 Name of person: _____ Signed: _____

Parent's Names (if applicable) _____

Person to Notify in Case of Emergency: _____ Phone #: _____

Name of Legally Responsible Representative: _____

Relationship to Patient: _____

***A copy of Power of Attorney must be on file, if one exists.

Street Address: _____

City, State, Zip: _____ Telephone: _____

Insurance Information

Primary Insurance:	Secondary Insurance:
Name of Primary Insured:	Name of Secondary Insured
Primary Insured Date of Birth:	Secondary Insured Date of Birth:
Policy #:	Policy #:
Patient Relationship to Insured:	Patient Relationship to Insured:

Referring Physician Information

Referring Physician:	Pediatrician/Family Doctor:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
Telephone #:	Telephone #:

Patient Medical History

Describe the reason for today's visit:

MEDICATION ALLERGIES: (list all medication allergies and reactions)

Latex Allergy ? Yes No

Have you ever had an endoscopic procedure? Yes No Reason: _____ Date: _____

Past Medical History:

Past Surgical History:

Do you take any of the following? Coumadin/Warfarin: Y/N Plavix: Y/N Aspirin: Y/N NSAIDs: Y/N

PRESENT MEDICATIONS: (**list all medications *including the dosage and frequency of use*; include any vitamins/ supplements/over the counter medication and herbals)

Do you smoke cigarettes? Yes No If yes, how much and for how many years
 If you previously were a smoker and quit, please tell us how much you did smoke, for how many years and how long ago did you quit smoking.
 Do you drink alcohol? Yes No If yes, then how much?
 Do you have a family history of any of the following? Hypertension, epilepsy, cancer, heart attack, stroke, diabetes, asthma, hearing loss?
 Yes No Please list:

Do you currently suffer from any of the following? Please check Yes or No

	Yes	No		Yes	No		Yes	No
Fever			Frequent Cough			Persistent Itch		
Headaches			Wheezing			Boils		
Chills			Shortness of Breath			Skin Cancer		
Weight Loss			Abdominal Pain			Tremors		
Blurred Vision			Nausea or Vomiting			Dizzy Spells		
Double Vision			Diarrhea			Stroke		
Glaucoma			Hepatitis			Seizures/Convulsions		
Eye Pain			Constipation			Numbness or Tingling		
Ear Infection			Indigestion/Heartburn			Depression		
Sinus Problems			Female:			Excessive Thirst		
Difficulty Swallowing			LMP			Too Hot or Too Cold		
Sore Throat			Vaginal Bleeding			Diabetes		
Hoarseness			Pregnant			Tired and Sluggish		
Chest Pain			Sexual Problem			HIV+		
High Blood Pressure			Joint Replacement			Blood clotting problem		
Valve Replacement			Neck Pain			Swollen Glands		
Varicose Veins			Joint Pain			Food Allergy		
Heart Murmur			Back Pain			Drug Allergy		
Asthma			Skin Rash			Hayfever		

Reviewed by Dr. _____

I authorize the release of medical information which could include HIV status, communicable disease, or drug abuse information to and from my primary care and referring physician(s), outside laboratories or consultants, if needed, in the course of my examination and treatment and as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing. I also authorize payment of medical benefits to Dr. Schaeffer, Dr. Ephrat, Otolaryngology-Facial Plastic Surgery of LI, P.C. and NY Facial Surgical Facility, LLP.

By signing this form I assure the information provided is complete and accurate to the best of my knowledge. If any of the above information should change, I understand that it is my responsibility to inform the organization of such changes. I have reviewed and understand, and a copy of the following information has been made available to me: Information regarding the ownership of the practice; the expertise of the associated physicians; the Patient Rights and Responsibilities; the Patient Grievance Process; DNR policy; Notice of Privacy Practice, and infection control process of this organization.

Signature of Patient or Responsible Party

Printed Name

Date