Otolaryngology-Facial Plastic Surgery of Long Island, P.C. - NY Facial Surgical Facility, LLP
B. Todd Schaeffer, M.D., FACS Moshe Ephrat, M.D., FACS

Patient information

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

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 give permission to disclose my personal health information to the following family member:
Name: Relation Signed:

Parent's Names (if applicable)

Parent or Guardian accompanying minor:

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.

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:

ALLERGIES TO MEDICATIONS: **(list all allergies to medications and reactions)**

Medication:	**Reaction:**

Latex Allergy ? Yes [_] No [_]

Past Medical History:

Past Surgical History:

Do you presently take any of the following? Coumadin: Y/N Plavix: Y/N Aspirin:Y/N Advil/Motrin:Y/N

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

MEDICATION/Supplement	Dosage/frequency	MEDICATION/Supplement	Dosage/frequency
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how much and for how many years

If previous smoker, tell us when you stopped, how much you smoked and for how long:

Do you drink alcohol? ☐ Yes ☐ No If yes, then how much?

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**