

**PATIENT INFORMATION:**

Please complete all three sections of this page and read the reverse side carefully and sign.

NAME		DATE OF BIRTH	GENDER	MARITAL STATUS
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE #	(OK TO LEAVE MESSAGE?) CIRCLE ONE YES NO	CELL PHONE #	(OK TO LEAVE MESSAGE?) CIRCLE ONE YES NO	
CONFIDENTIAL FAX #	E-MAIL ADDRESS	PAGER #	SOCIAL SECURITY #	
NAME OF EMPLOYER/SCHOOL	YOUR WORK PHONE #	(OK TO LEAVE MESSAGE?) CIRCLE ONE YES NO	OCCUPATION	
ADDRESS	CITY	STATE	ZIP	
IN CASE OF EMERGENCY, CONTACT: NAME			PHONE	
REFERRING PHYSICIAN, PERSON OR INSTITUTION (WHO ADVISED YOU TO BE EVALUATED BY THIS SURGEON)				

**RESPONSIBLE FINANCIAL PARTY (if not the patient):**

NAME (PARENT OR SPOUSE IF INDICATED)		RELATIONSHIP TO PATIENT		
HOME PHONE	(OK TO LEAVE MESSAGE?) CIRCLE ONE YES NO	BUSINESS PHONE	(OK TO LEAVE MESSAGE?) CIRCLE ONE YES NO	CELL PHONE
				(OK TO LEAVE MESSAGE?) CIRCLE ONE YES NO
ADDRESS	CITY	STATE	ZIP	
E-MAIL ADDRESS	CONFIDENTIAL FAX	DATE OF BIRTH	SOCIAL SECURITY #	
NAME OF THEIR EMPLOYER				
ADDRESS	CITY	STATE	ZIP	

**INSURANCE INFORMATION (PLEASE OBTAIN THIS INFORMATION FROM INSURANCE ID CARD):**

PRIMARY INSURANCE				
ADDRESS	CITY	STATE	ZIP	
INSURANCE ID #	POLICY HOLDER			
TYPE OF COVERAGE	LOCAL/GROUP			
SECONDARY INSURANCE				
ADDRESS	CITY	STATE	ZIP	
INSURANCE ID #	POLICY HOLDER			
TYPE OF COVERAGE	LOCAL/GROUP			

## CLAIMS AUTHORIZATION

Please be advised that payment is due and payable at the time services are rendered. **It is the obligation of the patient to make payment and not that of the insurance carrier or HMO.**

Your Surgeon's Business Office will be glad to complete and submit any and all insurance forms, but follow-up is the responsibility of the contract holder.

### **1. Blue Shield Plan or other insurance**

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to Blue Cross and Blue Shield of Greater New York or other insurer.

I also authorize Blue Cross and Blue Shield of Greater New York or other insurer, to disclose to a hospital, health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with Blue Cross and Blue Shield of Greater New York or other insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators."

### **2. Medicare**

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by the physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Medical Questionnaire Name \_\_\_\_\_ Date \_\_\_\_\_

(Please fill out the back of this sheet also)

I. WHAT SYMPTOM OR PROBLEM BRINGS YOU HERE TODAY? (Why are you here today?)

\_\_\_\_\_

II. LIST ALL PAST AND PRESENT MEDICAL CONDITIONS AND/OR HOSPITALIZATIONS.

For example, high blood pressure, diabetes, etc. (Do not list operations here.)


III. LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS YOU CURRENTLY TAKE.

MEDICATION	DOSE	FREQUENCY/DAY	MEDICATION	DOSE	FREQUENCY/DAY

IV. LIST ALL ALLERGIES TO MEDICATIONS AND THE REACTIONS YOU EXPERIENCED.

MEDICATION	REACTION YOU HAD	MEDICATION	REACTION YOU HAD

V. LIST ALL OPERATIONS. ALSO, ANY ADVERSE REACTION TO THE ANESTHETIC OR SURGERY.

OPERATION	ADVERSE REACTION (IF ANY)	OPERATION	ADVERSE REACTION (IF ANY)

VI. ANESTHESIA HISTORY

HAS ANYONE IN YOUR FAMILY HAD A SERIOUS REACTION TO AN ANESTHETIC (GENERAL, SPINAL, OR LOCAL)? IF SO, PLEASE DESCRIBE.

\_\_\_\_\_

DO YOU HAVE ANY OF THE FOLLOWING (please circle): UPPER DENTURES, LOWER DENTURES, CAPS, LOOSE TEETH, CHIPPED TEETH, CONTACT LENSES, SLEEP APNEA, REFLUX OR HIATAL HERNIA (GERD), LATEX ALLERGY, TMJ HISTORY OF A HEART ATTACK, HEART FAILURE, HEART EVALUATION, HYPERTHERMIA DURING ANESTHESIA (YOU OR A RELATIVE), KIDNEY FAILURE, TAKE BLOOD THINNERS, PREDNISONE OR INSULIN

VII. HOW MANY DAYS PER MONTH DO YOU DRINK ALCOHOLIC BEVERAGES? \_\_\_\_\_  
What? \_\_\_\_\_ How much per day on the days that you do drink? \_\_\_\_\_

IF YOU CURRENTLY SMOKE OR HAD SMOKED, HOW MANY PACKS PER DAY AND FOR HOW MANY YEARS? \_\_\_\_\_ packs per day \_\_\_\_\_ years currently smoking? (circle) yes no never

VIII. LIST ANY FIRST DEGREE BLOOD RELATIVE (parent, brother, sister, children) WHO DEVELOPED A SERIOUS MEDICAL ILLNESS BEFORE AGE 60.

RELATIVE	DISEASE CONTRACTED	AGE CONTRACTED

OVER

Name: \_\_\_\_\_

Date: \_\_\_\_\_

LIST YOUR: HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ USUAL BLOOD PRESSURE (if you know it) \_\_\_\_\_

**X. HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS (PLEASE CHECK IF YES)**

**NOW PAST**

NOW	PAST	
		Loss of weight
		Loss of appetite
		Excessive fatigue
		Night sweats
		Fever with chills
		Skin trouble/change
		Easy bleeding/bruising
		Transfusions
		Varicose veins
		Anemia
		Sickle cell
		Enlarged glands
		Headaches
		Seizures (fits)
		Dizziness
		Stroke
		Ringing in ears
		Deafness
		Other ear trouble
		Sinus trouble
		Nosebleeds
		Trouble swallowing
		Sore tongue
		Bleeding gums
		Eye trouble
		Glaucoma
		Cataracts
		Hayfever
		Asthma
		Emphysema
		Bronchitis
		Pneumonia
		Chronic cough
		Coughing blood
		Positive T.B. test
		Wheezing
		Family history of Colon cancer
		Family history of Pancreatic cancer
		Family history of Prostate cancer

**NOW PAST**

NOW	PAST	
		Chest pains
		Heart attacks
		High blood pressure
		Valvular heart disease
		Shortness of breath
		Heart murmurs
		Palpitations (rapid heart)
		Swollen ankles
		Calf (leg) pain with walking
		Heart condition /failure
		Vomiting
		Vomiting blood
		Yellow jaundice
		Liver disease
		Hepatitis
		Gallstones
		Diarrhea
		Constipation
		Bloody B.M.'s
		Black B.M.'s
		Stomach cramps/pain
		Colitis/spastic colon
		Bloating
		Belching
		Hemorrhoids
		Ulcers (stomach)
		Kidney infection
		Kidney stones
		Urine stream slow or poor
		Painful urination
		Frequent urination
		Urination at night
		Urine infection
		Bloody urine
		Kidney failure
		Venereal Disease
		Urine incontinence
		Cystoscopy
		Swollen glands
		Joint pain
		Leg cramps

**NOW PAST**

NOW	PAST	
		Back pain
		Neck pain
		Arthritis
		Gout
		Slipped disc
		Diabetes
		Increased thirst
		Thyroid trouble
		Mental illness
		Depression
		Excessive worry
		Thoughts of suicide
		Sexual problem
		Alcohol problem
		Drug problem
		Emotional problem
		Infertility
		Latex allergy
		<b>FOR WOMEN ONLY</b>
		Tube infection
		PAP smear abnormal
		PAP, last done more than 3 years ago
		Bleeding after menopause
		Breast lumps
		Abnormal mammogram
		Nipple discharge
		Breast cancer (you)
		Family history of breast cancer
		History of uterine cancer or ovarian cancer (yourself)
		Possibility of current pregnancy
		Last menstrual period date

Have you ever had a colonoscopy? Yes No (please circle) If so, when? \_\_\_\_\_ why? \_\_\_\_\_

Please use the space below to describe any of the problems checked above and/or any other medical problems  
**THIS IS VERY IMPORTANT.**

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