SIDNEY M. FISHMAN, M.D. F.A.C.S.
PATIENT INFORMATION

PLEASE COMPLETE & SIGN THIS FORM. PLEASE PRINT!

PATIENT NAME: _____ SEX: M F STATUS: M S W

PRIMARY LANGUAGE _____ ETHNICITY _____ RACE _____

AGE: _____ DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBERS: HOME # _____ CELL # _____

EMAIL _____

PERSON TO CONTACT IN CASE OF EMERGENCY: NAME: _____ PHONE: _____

EMPLOYER: NAME: _____ WORK # _____

ADDRESS: _____ CITY: _____ STATE: _____

PRIMARY INSURANCE COMPANY: NAME: _____

NAME OF SUBSCRIBER: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: (PLEASE CHECK ONE)_____ SELF _____ SPOUSE _____ CHILD _____ OTHER

POLICY #: _____ GROUP #: _____

SECONDARY INSURANCE COMPANY: NAME: _____

NAME OF SUBSCRIBER: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: (PLEASE CHECK ONE)_____ SELF _____ SPOUSE _____ CHILD _____ OTHER

POLICY #: _____ GROUP #: _____

WHAT DOCTOR/PERSON REFERRED YOU TO SEE THE DOCTOR TODAY?

NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE:____ ZIP CODE:_____

DO YOU HAVE A FAMILY DOCTOR? NAME: _____

ADDRESS: _____ PHONE: _____

CITY : _____ STATE: _____ ZIP CODE: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized insurance benefits be made either to me or on my behalf to Dr. Fishman for any services that Dr. Fishman provides. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits or the payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information to pay the claim. I understand that I am financially responsible for the balance not covered by my insurance. Any account balances which remain outstanding are subject to a $5.00 per month billing charge. If I fail to make payment and the balance of my account is placed for collection, I will be responsible for reasonable collection costs, including attorney's fees.

Patient Signature: _____ Date: _____

PATIENT INFORMATION

CC What is the main reason you are here to see the doctor? _____

_____

PMH Do you have any problems with your health? ☐ Yes ☐ No
If yes, please check those given below of list them on the line provided.

☐ Diabetes	☐ High Blood Pressure	☐ Lung Disease	☐ Hepatitis	☐ Ulcer
☐ Bleeding Problems	☐ Heart Attack	☐ Asthma	☐ HIV+	☐ Tuberculosis
☐ Scarring Problems	☐ Stroke	☐ Heart Disease	☐ AIDS	☐ Problem with Anesthesia

Other:

_____

MEDS Do you take medications every day? ☐ Yes ☐ No
If yes, please list the medications including dosage and frequency. _____

_____

_____

Have you taken Aspirin in the last 2 weeks? ☐ Yes ☐ No

ALLERGIES Do you have an allergy to any medications or have you ever had allergic reaction to a medication?
☐ Yes ☐ No If yes, please list the medication(s) and the allergic reactions:

_____

PHS Have you ever had surgery in your lifetime? ☐ Yes ☐ No
If yes, please list all the surgeries including the year

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

FH Please check if any of your immediate family members has ever had any of the following:
☐ Bleeding Disorder ☐ Heart Disease ☐ Autoimmune Disease ☐ Anesthesia Complications ☐ Diabetes
☐ Other: _____

SH Have you ever smoked?	☐ Yes	☐ No	☐ Quit When _____
Do you drink alcohol regularly?	☐ Yes	☐ No	☐ Quit When _____
Have you ever used cocaine?	☐ Yes	☐ No	☐ Quit When _____
Have you ever used intravenous drugs?	☐ Yes	☐ No	☐ Quit When _____

What is your occupation? _____

ROS Please check any of the items below which are currently true:

Eyes:	☐ Itching ☐ Dry Eyes	☐ Changes in Visions ☐ Discharge	☐ Pain	☐ Excessive Tearing	☐ Wear Glasses/Contacts
Ears:	☐ Pain ☐ Ringing	☐ Hearing Loss ☐ Wear Hearing Aid	☐ Dizziness/Imbalance ☐ Fullness	☐ Swelling	☐ Drainage
Nose & Sinuses:	☐ Breathing Problems ☐ Sneezing	☐ Post Nasal Drip ☐ Sinus Pressure/Pain	☐ Loss of Smell ☐ Deformity	☐ Bleeding	☐ Drainage
Mouth & Throat:	☐ Difficulty Breathing ☐ Pain ☐ Sing/Yell Often	☐ Hoarseness ☐ Chew Tobacco	☐ Wear Dentures ☐ Reflux	☐ Sores ☐ Difficulty Speaking	☐ Difficulty Swallowing ☐ Snoring
Face & Neck:	☐ Pain ☐ Scarring	☐ Lump	☐ Swelling	☐ Skin Growth	☐ Numbness
General:	☐ Fever	☐ Weight Loss	☐ Easy Bruising	☐ Fatigue	☐ Chills
Musculoskeletal:	☐ Muscle Weakness	☐ Joint Pains	☐ Joint Swelling	☐ Joint Stiffness	☐ Muscle Cramps/Aches
Cardiovascular:	☐ Chest Pain ☐ Edema	☐ Palpitations ☐ Dysnea	☐ Diaphoresis ☐ Orthopnea	☐ Arm pain/Tingling/Numbness	
GI/GU:	☐ Nausea ☐ Back Pain	☐ Vomiting ☐ Dysuria	☐ Diarrhea ☐ Urinary Frequency	☐ Abdominal Pain ☐ Hematuria	☐ Muscle Weakness ☐ Suprapubic Pain
Respiratory:	☐ Cough ☐ Wheezing	☐ Sputum ☐ Shortness of Breath	☐ Rhinorrhea	☐ Nasal/Sinus Congestion	☐ Chest Congestion
Neurologic:	☐ Headaches ☐ Numbness	☐ Dizziness ☐ Facial Drooping	☐ Photophobia	☐ Neck Stiffness	☐ Weakness
Psych:	☐ Depression	☐ Anxiety	☐ Insomnia	☐ Suicidal Ideations	☐ Homicidal Ideations
Skin/Derm:	☐ Rashes ☐ Unsual Moles/Skin Growth	☐ Hair Loss	☐ Itch	☐ Skin Iritation	

Thank you very much for completing this form. This information will help the doctor care for you.