Name:________________________________SSN:______________________________
____

Patient Medical Information

Name: First________________________ Middle________________________

Last____

Sex: M / F Age: ______ Date of Birth: ____________________

Social Security # _______________ Driver's License # ________________

Home Address: ____

City: _______________________ State: ____________ Zip Code: ___________

Home Phone: ______________________ Cell: ____________________________

Occupation:________________________ Employer: ________________________

Business Address: ____

City: _______________________ State: ____________ Zip Code: ___________

Marital Status: ____________ Spouse/Significant Other: __________________

Cell: _____________________________ Business/Other Phone: _____________

Email: ____

Insurance Information

Our office policy requests copies of both your insurance card(s) and picture ID

Primary Insurance:
Company ___________________________
Subscriber Name ____________________
DOB ______________________________
Social Security # ____________________
Group # ____________________________
Subscriber # _________________________

Secondary Insurance:
Company ___________________________
Subscriber Name ____________________
DOB ______________________________
Social Security # ____________________
Group # ____________________________
Subscriber # _________________________

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with (name of insurance companies)___________________________________ and assign directly to Dr. Mark Schlesinger all insurance benefits, if any, otherwise directly payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurances. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

________________________________ ______________________ ___________
Responsible Party Signature Relationship Date

Name:________________________________SSN:______________________________
____

Who is your primary care physician? __________________________________

Who referred you to our office? ___________________________________

Complete list of Physicians:

Cardiologist	__________________________	Phone	_______________________
Neurologist	__________________________	Phone	_______________________
Orthopedic Surgeon	__________________________	Phone	_______________________
Neurosurgeon	__________________________	Phone	_______________________
Other Physician	__________________________	Phone	_______________________
Other Physician	__________________________	Phone	_______________________
Other Physician	__________________________	Phone	_______________________
Other Physician	__________________________	Phone	_______________________

RPMHx

Do you have a history of:

Spinal Fracture   Spinal Curvature   Arthritic Conditions   Fibromyalgia

Disc Disease   Spinal Stenosis   Obesity

Do you have?

Bowel Incontinence   Bladder Incontinence   Weakness/Coordination Problems

Past Medical History (circle all that apply)

Cardiovascular

High Blood Pressure	Low Blood Pressure	Embolism	Heart Attack
Arterial Insufficiency	Venous Insufficiency		

Respiratory

Asthma	Emphysema	Chronic Bronchitis	Frequent Pneumonia
Frequent Colds	Productive Cough	Positive TB test	Abnormal CXR

Gastrointestinal

Acid Reflux	Ulcers	Polyps	Hepatitis
Pancreatitis	Bowel Problems	Colitis	Hiatal Hernia
Gallbladder Problems	Irritable Bowel Synd.	Crohn’s Disease	

Endocrine

Obesity	Hypothyroidism	Diabetes	Insulin

Hematologic

Anemia	Blood Clots

Neurologic			
Memory Problems	Seizures	Stroke	Movement Disorders

Name:________________________________SSN:______________________________
____

Muscular Dystrophy	Polio	Neuropathy	Epilepsy
Migraines	Chronic Headaches		
Psychological			
Nervous Breakdown	Depression	Anxiety	Panic Disorders
Claustrophobia	Psychosis	Alcohol Abuse	Drug Abuse
Genitourinary			
Sexual Dysfunction	STD's	Prostate Problems	Kidney Problems
Bladder Problems	Chronic Infection	Incontinence	
Musculoskeletal			
Fibromyalgia	Rheumatoid Arthritis	Osteoarthritis	Osteoporosis
Back Problems	Neck Problems	Scoliosis	
Cancer History			
Site	Date of Diagnosis	Chemotherapy	Radiation

Have you ever been tested for HIV? Y / N Results: ______________________

Have you ever been tested for Hepatitis? Y / N Results: ______________________

Have you ever had a blood transfusion? Y / N Dates: _______________________

Are you taking any blood thinners such as Coumadin, Plavix or Ticlid? ______________

Please list all of your **Medicines.**

Medicine	Dose	Starting Date	Times per day	As Needed	Pills per day

Name:________________________________SSN:______________________________
____

Please list all of your **allergies**. (None)

Medication	Reaction

Local Pharmacy: (Where would you like your prescriptions to be filled?)
Name __________________________________ Phone # ________________
Address __________________________________ Fax # ________________

Family History

Relative	Condition 1	Condition 2	Condition 3	Condition 4
Father				
Mother				
Brother				
Sister				
Other				

Surgical History
Please List All
Operations:

Procedure | Date | Surgeon

________________________ ______ _________________________

________________________ ______ _________________________

________________________ ______ _________________________

________________________ ______ _________________________

________________________ ______ _________________________

________________________ ______ _________________________

________________________ ______ _________________________

________________________ ______ _________________________

Name:________________________________SSN:______________________________
____

Nerve Blocks:

Procedure	Date	Surgeon
________________________	_______	_________________________
________________________	_______	_________________________
________________________	_______	_________________________
________________________	_______	_________________________

Social History

Education

Highest Level Completed High School College Graduate School

Work History

Job: ____

Employer: ____________________________________

Full Time Part Time Disabled Since: __________________

Marital Status

Single Married Widowed Divorced Other: _____________

Smoking

Never Started: ______ Stopped: _______ Packs per day: _______

Alcohol

Never Rarely Socially Daily # of Drinks __________

Have you ever been treated for Alcoholism? Y / N

If so, how long have you been sober? __________________

Height: ____________________ Weight: _______________________

Have there been any recent changes?

Name:________________________________SSN:______________________________
____

Please circle all that apply.

ROS:

Constitutional			
HEENT	Vision loss	Hearing Loss	Vertigo
Respiratory	Cough	Dyspnea	Wheezing
Cardiovascular	Chest Pain	Cyanosis	Irregular heart beat
Gastrointestinal	Constipation	Diarrhea	Nausea or Vomiting
Genitourinary	Blood in Urine	Dysuria	
Metabolic/Endocrine	Cold Intolerance	Heat Intolerance	Weight changes
Neuro/Psychiatric	Difficulty walking	Dizziness	Headache
Dermatologic	Acne	Contact allergy	Rash
Musculoskeletal	Joint Symptoms	Muscle weakness	Stiffness
Hematologic	Bleeding Disorders	Blood Clots	Easy Bruising
Immunologic	Bee Sting Allergies	Environmental Allergies	Food Allergies