H. ALAN SCHNALL, M.D.

New Patient: _____ Established Patient:_____ Today's Date: _____

Change of Address:_____ Change of Insurance _____

Patient's Name: _____ Date of Birth: _____

Home Address: _____ Age:_____ Sex: _____ SS # _____

_____ Phone/Cell # _____

_____ Email: _____

Employer: _____ Occupation _____

Address: _____ Work Phone: _____

_____

Referred by: _____ Phone # _____

Next of Kin: _____ Phone #: _____

Relationship: _____

PRIMARY INSURANCE

Name: _____

Billing Address: _____

_____

Certificate #: _____

Group #: _____

Name of Insured: _____

SECONDARY INSURANCE

Name: _____

Billing Address: _____

_____

Certificate #: _____

Group #:_____

Name of Insured: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plan to Dr. Alan Schnall.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

Signed: _____ Date: _____

H. ALAN SCHNALL, M.D.

Name: _____ Date: _____

Referring Doctor: _____

Present Complaints: _____

PAST MEDICAL HISTORY

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

___ Liver disease	___ Rheumatic Fever	___ Heart Attack	___ COPD
___ Anemia	___ Epilepsy (Seizure)	___ Kidney Disease	___ Liver Disease
___ Arthritis	___ Venereal Disease	___ Stroke	
___ Asthma	___ Colon Polyp	___ Ulcer	
___ Diabetes	___ High Blood Pressure	___ Cancer	
___ Emphysema	___ High Cholesterol	___ Jaundice	
___ Hypothyroidism	___ Anxiety	___ Sleep Apnea	___ CPAP Machine

Other: _____
Surgery (Operations): _____
History of anticipated intolerance to standard sedative?_____

HABITS

Smoke: ___YES ___ NO If yes, How many per day? ___ How Long? ____When Stopped? _____

Alcohol ___YES ___ NO If yes, Type_____ Amount? _____How long?_____ When Stopped?_____

Exercise: ___YES ___ NO If yes, Type _____How frequent?_____ Coffee? (# of cups daily) _____

Drug Abuse ___YES ___ NO If Yes, Type? _____How long? _____When Stopped?_____

Blood Thinners, Steroids or Cortisone? ___YES ___NO

FAMILY HISTORY

	FATHER	MOTHER	SIBLINGS	CHILDREN	MOTHER'S PARENTS	FATHER'S PARENTS
HYPERTENSION						
STROKE						
CANCER						
DIABETES						
ULCER						
BLEEDING DISORDER						
KIDNEY DISEASE						
HEART DISEASE						
OTHER						

ANY OTHER INFORMATION WHICH YOU MAY FEEL MAY BE HELPFUL:

_____

_____

H. ALAN SCHNALL, M.D.

Patient Name: _____

Your Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Do you have a pacemaker or a defibrillator? _____If yes, please bring your card with you.

It is very important that you bring this completed list to your appointment.

List all medications you are taking by name, the strength of each dose and how often you take it. Include hormones, diet pills, vitamins, cold tablets and over the counter laxatives, herbs, enzymes, aspirin, etc.

Medication	Dosage / Strength (example: mg)	What are the directions on the prescription / bottle?
Please use other side if necessary		

STATE LAW REQUIRES YOU TO LIST YOUR ALLERGIES AND TYPE OF REACTIONS

Please list your **ALLERGIES**: Medications, foods, or other items (i.e. latex)	What type of **REACTION** do you have?
Please use other side if necessary	

Chief Complaint (why are you seeing the doctor today?)_____

_____

_____