Steven & Alexandra Cohen
Children's Medical
Center of NY

Division of Pediatric Neurosurgery

Steven J. Schneider, MD
Mark A. Mittler, MD
Shaun D. Rodgers, MD
Shanna L. Baron, FNP-C

PLEASE FILL OUT FORM BELOW AND THEN FAX BACK TO: 516-354-8597

ADDITIONALLY, PLEASE BRING FORM WITH YOU ON THE DAY OF YOUR SCHEDULED APPOINTMENT.

THANK YOU

Steven & Alexandra Cohen
Children's Medical
Center of NY

Division of Pediatric Neurosurgery

Steven J. Schneider, MD
Mark A. Mittler, MD
Shaun D. Rodgers, MD
Shanna L. Baron, FNP-C

NEW PATIENT MEDICAL INFORMATION

Patient Name:_____ Today's Date:_____

Gender: Male [ ] Female [ ] Date of Birth:_____ Age:_____ Height:_____ Weight:_____

Race: o American Indian or Alaskan Native o Asian o Black or African-American o More Than One Race
o Native Hawaiian o Other Pacific Islander o White o Refused to Report/Unreported

Ethnicity: o Hispanic or Latino o Non-Hispanic or Latino o Refused to Report/Unreported

Language: o English o Spanish o Other: _____

Reason for Consultation (include symptoms / signs if any):_____
_____
_____
_____
_____
Date of Onset (may approximate):_____

Previous/Existing Medical Conditions (list):_____
_____
_____
Previous Surgical Procedures (list with approximate dates):_____
_____
_____
Current Medications (with dosages):_____
_____

Local Pharmacy: _____ Town: _____ Telephone Number:(_____) _____- _____

Mail Order Pharmacy: _____ Telephone Number: (_____) _____ - _____

Medication or Environmental Allergies (list with symptoms / signs):_____
_____

Family History – Please indicate any relevant family history and which family members it pertains to:_____
_____

Social History:
Dominant Hand: o Right handed o Left handed o Ambidextrous
Is the patient currently enrolled in school? If so, what grade or level?_____
Does the patient participate in any physical activities? o Yes o No
If so, what types of activities?_____
_____

Please describe your Current Tobacco Use?(Skip, if patient is young child)o Smoker, current status unknown o Light tobacco smoker
o Heavy tobacco smoker o Current everyday smoker o Current some day smoker o Never smoker o Unknown if ever smoked

I certify that the above information is accurate to the best of my knowledge: Signature **X**_____

Steven & Alexandra Cohen
Children's Medical
Center of NY

Division of Pediatric Neurosurgery

Steven J. Schneider, MD
Mark A. Mittler, MD
Shaun D. Rodgers, MD
Shanna L. Baron, FNP-C

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor or nurse practitioner will discuss any positive responses with you.

General:
- ❑ Chills
- ❑ Fever
- ❑ Night Sweats
- ❑ Significant Weight Change
- ❑ Other: _____

Skin:
- ❑ Bruising
- ❑ Dryness
- ❑ Excessive Sweating
- ❑ Hair Loss
- ❑ New Lesions
- ❑ Rash
- ❑ Other: _____

HEENT:
- ❑ Blurred Vision
- ❑ Hearing Loss
- ❑ Seasonal Allergies
- ❑ Other: _____

Neck:
- ❑ Neck Mass
- ❑ Swollen Glands
- ❑ Other: _____

Respiratory:
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Sleep Apnea
- ❑ Wheezing
- ❑ Other: _____

Cardiovascular:
- ❑ Anemia
- ❑ Bleeding Tendency
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Leg Pain and/or Swelling
- ❑ Other: _____

Gastrointestinal:
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting
- ❑ Other: _____

Genitourinary:
- ❑ Frequency
- ❑ Incontinence
- ❑ Painful Urination
- ❑ Other: _____

Musculoskeletal:
- ❑ Upper Back Pain
- ❑ Lower Back Pain
- ❑ Joint Swelling
- ❑ Other: _____

Endocrine/Glands:
- ❑ Appetite Changes
- ❑ Excessive Urination
- ❑ Thyroid Problems
- ❑ Other:

Neurological:
- ❑ Fainting
- ❑ Difficulty Walking
- ❑ Dizziness
- ❑ Headache
- ❑ Loss of Consciousness
- ❑ Migraines
- ❑ Numbness
- ❑ Weakness
- ❑ Seizures
- ❑ Tingling
- ❑ Other: _____

Hematology:
- ❑ Anemia
- ❑ Blood Clots
- ❑ Easy Bruising
- ❑ Easy Bleeding
- ❑ Enlarged Lymph Nodes
- ❑ Other: _____

Psychiatric:
- ❑ Anxiety
- ❑ Depression
- ❑ Easily Irritated
- ❑ Memory Loss
- ❑ Suicidal Thoughts
- ❑ Other: _____

□ **None of the Above**

Steven & Alexandra Cohen
Children's Medical
Center of NY

Division of Pediatric Neurosurgery

Steven J. Schneider, MD
Mark A. Mittler, MD
Shaun D. Rodgers, MD
Shanna L. Baron, FNP-C

NEW PATIENT DEMOGRAPHICS

Patient:

Name (Last, First): _____ Date of Birth: _____ Age: _____

Home Telephone Number: (_____) _____ -_____ **Cell Phone Number** (if adult): (_____) _____ -_____

Home Address (Street, City, State, Zip): _____

_____

_____

Email Address (if adult): _____

Lives with (circle) Mother / Father / Both / Other

Mother:

Name (Last, First): _____

Home Telephone Number (Leave blank if same as patient): (_____) _____ -_____

Home Address (Street, City, State, Zip) (Leave blank if same as patient): _____

_____

_____

Profession, Workplace Name: _____

Work Telephone Number: (_____) _____ -_____

Cell Phone Number: (_____) _____ -_____

Email Address (if child is below 18):_____

Father:

Name (Last, First): _____

Home Telephone Number (Leave blank if same as patient): (_____) _____ -_____

Home Address (Street, City, State, Zip) (Leave blank if same as patient): _____

_____

_____

Profession, Workplace Name: _____

Work Telephone Number: (_____) _____ -_____

Cell Phone Number: (_____) _____ -_____

Email Address (if child is below 18):_____

Other Guardian (If applicable – such as foster parent, guardian grandparent, etc):

Name (Last, First):_____ Relationship:_____

Home Telephone Number (Leave blank if same as patient): (_____) _____ -_____

Home Address (Street, City, State, Zip) (Leave blank if same as patient):_____

_____

_____

Profession, Workplace Name:_____

Work Telephone Number: (_____) _____ -_____

Cell Phone Number: (_____) _____ -_____

Steven & Alexandra Cohen
Children's Medical
Center of NY

Division of Pediatric Neurosurgery

Steven J. Schneider, MD
Mark A. Mittler, MD
Shaun D. Rodgers, MD
Shanna L. Baron, FNP-C

NEW PATIENT DEMOGRAPHICS

Patient Name:_____ Today's Date:_____

Pediatrician/Primary Care Provider:
Name:_____
Telephone Number: (_____) _____ -_____ Fax Number: (_____) _____ -_____
Address (Street, City, State, Zip): _____
_____
_____
Partners familiar with patient:_____
Pharmacy:_____ Town:_____ Phone Number:_____

Other Physician: (Specialty _____)
Name:_____
Telephone Number: (_____) _____ -_____ Fax Number: (_____) _____ -_____
Address (Street, City, State, Zip): _____
_____
_____
Partners familiar with patient:_____

Other Physician: (Specialty _____)
Name:_____
Telephone Number: (_____) _____ -_____ Fax Number: (_____) _____ -_____
Address (Street, City, State, Zip): _____
_____
_____
Partners familiar with patient: _____

INSURANCE INFORMATION

*****WE MUST MAKE A COPY OF ALL INSURANCE CARDS*****

PRIMARY Insurance:_____
Full name of policy holder:_____ **Date of Birth:**_____
Policy ID Number:_____ **Group Number**_____
Employer:_____
SECONDARY Insurance:_____
Full name of policy holder(if different from above):_____ **Date of Birth:**_____
Policy ID Number_____ **Group Number**_____

RELEASE

***Your Signature here allows for the RELEASE of medical information to your insurance company and for the direct assignment of benefits to our provider* X**_____ Date_____