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

NEW PATIENT MEDICAL INFORMATION

Patient Name:		Today's Dat	e:
Gender: Male [] Female [] Date of Birth:			
Race: o American Indian or Alaskan Native o Asian	o Black or A	frican-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 Lat	ino o Refuse	d to Report/Unrep	orted
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):			
Desired Consider Desired and With the considerate data a			
Previous Surgical Procedures (list with approximate dates):_			
Current Medications (with dosages):			
Local Pharmacy: Town:		Telephone Numb	oer:(
Mail Order Pharmacy:	Tele	ephone Number: (
Medication or Environmental Allergies (list with symptoms /	/ signs):		
Family History – Please indicate any relevant family history ar	nd which family	mamhars it nartains	to:
Social History:			
Dominant Hand: o Right handed o Left handed o Ambidex	xtrous		
Are you currently enrolled in school? If so, what grade or leve			
Do you participate in any physical activities? o Yes o No			
If so, what types of activities?			
Please describe your Current Tobacco Use? o Smoker, curre			smoker o Heavy tobacco smoker
o Current everyday smoker o Current some day smoker o	Former smoke	r o Never smoker	o Unknown if ever smoked
If past history of smoking or current smoker, please indicate: I	Packs per day	Total	Amount of Years Smoked
I certify that the above information is accurate to the hest of n	nv knowledae:	Sianature X	



General:

Other:

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Neurological:

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.

Cardiovascular:

Fever		Chills		Anemia		Fainting
Significant Weight Change Other:		Fever		Bleeding Tendency		Difficulty Walking
Leg Pain and/or Swelling Other:		Night Sweats		High Blood Pressure		Dizziness
Skin: Bruising Constipation Digrates Numbness Numbness Seizures Seizures Digrates Nausea Digrates Other: Digrates Dig		Significant Weight Change		High Cholesterol		Headache
Skin: Bruising Dryness Bruising Dryness New Lesions New Lesions New Lesions Dither: Seasonal Allergies Other: Seasonal Allergies Other: Neck: Neck Mass Seasonal Allergies Other: Neck Mass Seasonal Allergies Other: Neck Mass Seasonal Allergies Other: Neck Seasonal Allergies Other: Seasonal Allergies Other: Seasonal Allergies Other: Nother: Neck Seasonal Allergies Other: Seasonal Allergies Other: Nother: Nother: Nother: Nother: Nother: None of the Above		Other:		Leg Pain and/or Swelling		Loss of Consciousness
Skin: Bruising Dryness Dryness Skin: Secessive Sweating Hair Loss New Lesions Cother: Seasonal Allergies Other: Other: Seasonal Allergies Other: Other: Servey Seasonal Allergies Other: Other: Servey Seasonal Allergies Other: Servey Seasonal Allergies Seasonal Allergies Other: Other: Servey Special Changes Secures Secur				Other:		Migraines
Bruising			l			Numbness
Dryness Diarrhea Diarrhea Other: Other: Endocrine/Glands: Appetite Changes Excessive Urination Diarrhea Other: Excessive Urination Diarrhea Other: Excessive Urination Diarrhea Other: Excessive Urination Diarrhea Other: Diarrhea Other: Excessive Urination Diarrhea Other: Diarrhea Diarrhe	Skin:		Gastro	ointestinal:		Weakness
Diarrhea Diher: Dother: Dother: Dother: Dother: Diarrhea Dother:		Bruising		Constipation		Seizures
Rash Other: Appetite Changes Appetite Changes Appetite Changes Excessive Urination Thyroid Problems Other: Other: Other: Depression Easily Irritated Anxiety Depression Easily Irritated Depression Easily Irritated Depression Easily Irritated Depression Easily Irritated Other:		Dryness		·		Tingling
Hair Loss Vomiting Other: Appetite Changes Excessive Urination Thyroid Problems Excessive Urination Thyroid Problems Other: Other: Other: Other: Other: Other: Painful Urination Painful Urination Painful Urination Other:		Excessive Sweating				Other:
New Lesions		Hair Loss				
Rash Other: Appetite Changes Excessive Urination Thyroid Problems Other: Other: Other: Other: Painful Urination Other: Anxiety Psychiatric: Anxiety Depression Easily Irritated Depression Easily Irritated Depression Easily Irritated Depression Difficulty Breathing Blood Clots None of the Above No		New Lesions			Endo	crine/Glands:
Frequency Cher: Other: Other: Other: Depression Easily Irritated Memory Loss Other:		Rash				Appetite Changes
Frequency Other: Other: Depression Painful Urination Other: Depression Anxiety Other: Depression Easily Irritated Memory Loss Other: Othe		Other:	Genite	ourinary		Excessive Urination
Incontinence Other: Othe			,	•		Thyroid Problems
Blurred Vision	HEEN.	Г:	_			Other:
Hearing Loss Other:		Blurred Vision				
Seasonal Allergies Other:		Hearing Loss	-		Deveh	intric:
Musculoskeletal: Upper Back Pain Lower Back Pain Depression Easily Irritated Memory Loss Suicidal Thoughts Other: Other: Hematology: Respiratory: Anemia Blood Clots Blood Clots Blood Clots Blood Seep Apnea Easy Bruising Easy Bleeding		Seasonal Allergies		Other:] -	
Upper Back Pain Easily Irritated Memory Loss Joint Swelling Suicidal Thoughts Other: Other: Other: Hematology: Anemia Blood Clots None of the Above Easy Bleeding Easy Bleeding Easy Bleeding		Other:	Musci	uloskeletal:		·
Neck: Neck Mass]			
Neck Mass Joint Swelling Suicidal Thoughts Other: Other: Other: Other: None of the Above Easy Bleeding Easy Bleeding Other Other Other Other Other: O	Neck:] -	• •	-	•
Swollen Glands Other: Other: Hematology: Anemia Cough Difficulty Breathing Sleep Apnea Blood Clots Easy Bruising Easy Bleeding		Neck Mass				•
Hematology: Cough Difficulty Breathing Sleep Apnea Hematology: Anemia Blood Clots Easy Bruising Easy Bleeding				-		-
Respiratory: Cough Difficulty Breathing Sleep Apnea Hematology: Anemia Blood Clots Easy Bruising Easy Bleeding] "	other:
Respiratory: Cough Difficulty Breathing Sleep Apnea Anemia Blood Clots Easy Bruising Easy Bleeding			Hema	tology:		
□ Cough □ Difficulty Breathing □ Sleep Apnea □ Blood Clots □ Easy Bruising □ Easy Bleeding □ Cough □ Easy Bleeding	Respi	ratory:		- .		
□ Difficulty Breathing □ Easy Bruising □ Easy Bleeding □ Easy Bleeding	_	-	_			None of the Above
□ Sleep Apnea □ Easy Bleeding			_			None of the Above
	_	PILICUITY DICULIIIIS		-asy Di alsilig	1 1	
□ Wheezing □ Enlarged Lymph Nodes				Fasy Bleeding		

Other: _



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NEW PATIENT DEMOGRAPHICS

Patient:		
Name (Last, First):	Date of Birth:	Age:
Home Telephone Number: () C	ell Phone Number: ()	
Home Address (Street, City, State, Zip):		
Email Address:		
Profession, Workplace Name:		
Work Telephone Number: ()		
Lives with (circle): Spouse(or significant other) / Mother / Fath	ner / Both / Other	
Spouse/Significant Other:		
Name (Last, First):	Relationship:	
Home Telephone Number (Leave blank if same as patient): (
Home Address (Street, City, State, Zip) (Leave blank if same as pati		
Profession, Workplace Name:		
Work Telephone Number: ()		
Cell Phone Number: (
Emergency Contact:		
Name (Last, First):	Relationship:	
Home Telephone Number (Leave blank if same as patient): (
Home Address (Street, City, State, Zip) (Leave blank if same as pati		
	•	
Profession, Workplace Name:		
Work Telephone Number: ()		
Cell Phone Number: ()		



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NEW PATIENT DEMOGRAPHICS

Primary Care Provider: Name:				
Telephone Number: ())	
Address (Street, City, State, Zip):				
Other Physician: (Specialty (ie: Neu	ırology):)	
Name:				
Telephone Number: ()	<u> </u>	Fax Number: ()	
Address (Street, City, State, Zip):				
, , , , , , , , , , , , , , , , , , , ,				
-				
Other Physician: (Specialty(ie: Pain	Management).		1	
Name:			/	
Telephone Number: ()		Eav Number: (
Address (Street, City, State, Zip):				
				
				
Other Physician: (Specialty (ie: Card)	
Name:				
Telephone Number: ()				
Address (Street, City, State, Zip):				
		<u>INFORMATION</u>		
	WE MUST MAKE A COPY	OF ALL INSURANCE CARDS	S	
PRIMARY Insurance:				
			Date of Birth:	
Employer:				
SECONDARY Insurance:				
Full name of policy holder(if different from above): Date of Birth:				
Policy ID Number Group Number				
	·	<u>EASE</u>		
_	-		mpany and for the direct assignment of	
benefits to our provider X			Date	