NAME: ________________________

CHART: ________________________

DATE: ________________________

PAUL HAMMERSCHLAG, M.D., P.C.
863 PARK AVENUE, SUITE 1E
NEW YORK, NY 10075
TELEPHONE (212) 472-1300 FAX (212) 472-1336

Name: ____ Date: ______________________________

Home Address: ____ City: __________________________________

State: __________ Zip Code: __________ Email Address: ____

Home Phone: __________________ Business Phone: __________________ Cell Phone: __________________

Social Security Number: ___________________ Date of Birth: ____________________ Age: _________________

Marital Status: ______________ Sex: _____________

Occupation: _____________________________________ Employer: ______________________________________

Business Address: ____

City: ____ State: __________ Zip Code: __________

Emergency Contact: _____________________________ Cell Phone: _______________ Home Phone: _______________

RECEIVED NOTICE OF PRIVACY PRACTICE: _____

Primary Insurance:

Name of Insured: _______________________________

Relationship: __________________________________

Policy Number: _________________________________

Employer: _____________________________________

Insurance Company: ____________________________

Group Number: _________________________________

Secondary Insurance:

Name of Insured: _______________________________

Relationship: __________________________________

Policy Number: _________________________________

Employer: _____________________________________

Insurance Company: ____________________________

Group Number: _________________________________

Send Reports To:

Doctor: ____ Office Phone: ___________________________________

Address: ____

Referred By: ____ Phone: ____

Address: ____

Patient or Authorized Signature

This signature will act as a “SIGNATURE ON FILE” and will remain active for all claims.

Signature: ____ Date: ___________________________

NAME: ________________________

CHART: ________________________

DATE: ________________________

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Past Medical History (check all that apply to you, not your family)

Diabetes	Anemia	High Blood Pressure	Bleeding Disorder
Stroke	Cancer	Heart Disease	Liver Disease
Tuberculosis	Major Injuries	Kidney Disease	None of the Above

Have you ever been hospitalized or had surgery? Yes No (if yes, list dates below)

____
____
____

Are you taking any prescription or non-prescription medications? Yes No (if yes, please list below)

____
____
____

Do you have allergies? Yes No Not Sure

Please list any allergies to:
Medications: ____
Foods: ____
Other: ____

Have you ever received allergy shots? Yes No

Family History (check all that apply)

Heart Disease Bleeding Disorders Hearing Loss High Blood Pressure

Social History (questions may not apply to children)

Have you ever smoked cigarettes? Yes No How much? ____________ How long? ____________

Do you currently smoke cigarettes? Yes No

Do you use any other tobacco products? Yes No If yes, describe ______________________

Do you drink alcohol? Yes No How much? ____________________________________

Do you use any other drugs? Yes No

What is your weight? ______________________ What is your height? ______________________

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Please check any conditions or symptoms you have experienced. If you have not experienced any, check NONE.

General:

Weight Loss/Gain | Fever | Night Sweats | None

Ear, Nose, Mouth, and Throat:

Dizziness	Nasal Discharge	Ear Drainage	Hoarseness	Hearing Difficulty
Nose Bleeds	Sinus Pain	Imbalance	Nasal Stuffiness	Ear Pain
Sore Throats	Ringing in the Ear	Vertigo	Falling	None

Eyes:

Nearsightedness	Farsightedness	Glaucoma	Itching
Double Vision	Blurry Vision	Tearing	None

Respiratory:

Shortness of Breath | Pneumonia | Asthma | Bronchitis | Coughing | None

Gastrointestinal:

Difficulty Swallowing | Heartburn | Ulcers | Constipation | None

Cardiovascular:

Chest Pain | Palpitations | Murmurs | Pacemaker | None

Renal:

Urinary Retention | Kidney Stones | None

Endocrine:

Cold Intolerance | Heat Intolerance | Pituitary Disease | Menstrual Irregularity
Thyroid Disease | None

Immunologic:

Immune Deficiency | Allergies | None

Hematologic:

Anemia | Swollen Lymph Nodes | Easy Bruising or Bleeding | None

Neurologic:

Headaches | Weakness | Numbness | Migraines | Gait Disorder | Speech Disorder
None

Psychiatric:

Depression | Mania | Anxiety | Eating Disorder | Schizophrenia | None

Musculoskeletal:

Arthritis | Joint Swelling | Neck Pain | Back Pain | None

Skin:

Rashes | Itching | Moles | None

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: ____

Relationship To: ____

Patient's Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason: