Hyman Stadlen, MD

DATE: _____ / _____ / _____

PATIENT INFORMATION

LAST NAME: _____ **FIRST NAME:** _____ **M.I.** _____

DATE OF BIRTH _____ / _____ / _____ **Sex: M** ___ **F**___ **EMAIL**_____

ADDRESS: _____ **CITY** _____ **STATE** _____**ZIP**_____

RELATIONSHIP STATUS: MARRIED_____ **SINGLE**_____ **WIDOWED**_____ **DIVORCED** _____ **SEPERATED**_____

HOME PHONE: (_____) _____--_____ **WORK PHONE: (**_____) _____--_____**EXT** _____

CELL #: (_____) _____--_____ **EMERGENCY CONTACT:** _____ **PHONE (**_____) _____--_____

MEDICAL INSURANCE- KINDLY GIVE COMPLETE INFORMATION

PRIMARY INSURANCE PLAN: _____ **COPAY $** _____

ADDRESS: _____ **CITY** _____ **STATE** _____**ZIP**_____

INSURANCE ID#_____ **GROUP#**_____

INSURED PERSONS NAME_____ **EFFECTIVE DATE** _____ / _____ / _____

EMPLOYER NAME _____

SECONDARY INSURANCE PLAN: _____ **COPAY $** _____

ADDRESS: _____ **CITY** _____ **STATE** _____**ZIP**_____

INSURANCE ID#_____ **GROUP#**_____

INSURED PERSONS NAME_____ **EFFECTIVE DATE** _____ / _____ / _____

EMPLOYER NAME_____

NAME OF SPOUSE (OR PARENTS IF YOU'RE A MINOR) _____

ADDRESS (IF DIFFERENT FROM ABOVE): _____

PHONE (IF DIFFERENT FROM ABOVE): (_____) _____--_____ **DATE OF BIRTH** _____ / _____ / _____

EMPLOYER _____**PHONE: (**_____) _____--_____

PAYMENT IS EXPECTED AT TIME OF SERVICE

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to Dr. Hyman Stadlen for any balance which I have not paid in full at the time of service. I understand that I am financially responsible to the physician for any charges including copayments and deductibles not covered by my plan. I understand that my account will be charged up to $150 if I do not show up for an appointment without canceling at least 24 hours in advance. I authorize Dr. Stadlen and his agents to contact me via email or text message regarding any balances due. I also authorize the physician to release any information required for claim processing to my insurance carrier, etc.

_____ _____

SIGNATURE: PATIENT (OR PARENT IF A MINOR) **RELATIONSHIP TO PATIENT**

HYMAN STADLEN, M.D.

SUITE 1, HIGHLANDS PROFESSIONAL CENTER
2 STOWE ROAD
PEEKSKILL, NEW YORK 10566-2542

TEL (914) 736-2273 • **FAX** (914)736-2511 • Email: stadlenhs@yahoo.com

PATIENT NAME: _____ **DOB** ____ /_____ /_____

RELEASE FORM & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY INFORMATION

I _____ authorize Dr. Hyman Stadlen or
(Please Print)
any holder of medical information to release information to my health plan organization as well as the Healthcare Financing Administration and its agents. Release of Information may occur in the submission of claims, reports to establish medical necessity, and/or for other reviews required by my health plan.

I understand that I have the right to review any and all material released to my health plan before it is submitted.

Patient/Guardian: _____ Date: _____
(Signature)

Where applicable, I further assign direct payment of Medicare and other third party benefits and/or agree to give any payment(s) I receive directly from my insurer, to Dr. Hyman Stadlen provided he receives no more than the maximum fee per service.

I have received Dr. Hyman Stadlen's "Notice of Privacy Practices". I understand if I have any questions about the "Notice of Privacy Practices", I can speak with my provider.

Patient/Guardian: _____ Date: _____
(Signature)

If it is not possible to obtain the individual's signature acknowledging receipt of the Notice of Privacy Practices, please describe the good faith efforts made to obtain and the reason why the acknowledgement was not obtained.

_____
_____
_____
_____
_____

Provider's Signature _____ Date: _____

HYMAN STADLEN, M.D.

Patient History Intake Form

Patient Name:_____
Date of Birth:_____

Preferred Pharmacy_____ **Phone: (_____) _____--_____**

Medication list

Name	Dose	Frequency

Allergies

Medication name	Reaction

Other allergies:_____

Visit date:_____

Reason for your visit:_____

Immunizations:_____

Past Medical History

Head

- ☐ **Trauma**
- ☐ **Other** _____
  _____
  _____
  _____
  _____

Eyes

- ☐ **Blindness**
- ☐ **Cataracts**
- ☐ **Glaucoma**
- ☐ **Wears glasses/contacts**
- ☐ **Other** _____
  _____
  _____
  _____

Ears

- ☐ **Hearing aids**
- ☐ **Other** _____
  _____
  _____
  _____

Nose/Sinuses

- ☐ **Allergic rhinitis**
- ☐ **Sinus infections**
- ☐ **Other** _____
  _____
  _____
  _____

Cardiovascular

- ☐ **Aneurism**
- ☐ **Angina**
- ☐ **DVT**
- ☐ **High blood pressure**
- ☐ **Murmur**
- ☐ **Other** _____
  _____
  _____
  _____

Respiratory

- ☐ **Asthma**
- ☐ **Bronchitis**
- ☐ **COPD**
- ☐ **Other** _
  _____
  _____
  _____
  _____

Gastrointestinal

- ☐ **GERD**
- ☐ **Heartburn**
- ☐ **Hepatitis**
- ☐ **Other** _____
  _____
  _____
  _____

Genitourinary

- ☐ **Hernia**
- ☐ **Incontinence**
- ☐ **STDs**
- ☐ **UTI**
- ☐ **Other** _____
  _____
  _____
  _____

Musculoskeletal

- ☐ **Arthritis**
- ☐ **Dermatitis**
- ☐ **Other skin condition**
- ☐ **Other** _____
  _____
  _____
  _____

Neurological

- ☐ **Epilepsy**
- ☐ **Seizures**
- ☐ **Stroke**
- ☐ **Other** _____
  _____
  _____
  _____

Psychiatric

- ☐ **Bipolar**
- ☐ **Depression**
- ☐ **Suicide attempts**
- ☐ **Other** _____
  _____
  _____
  _____

Endocrine

- ☐ **High cholesterol**
- ☐ **Diabetes**
- ☐ **Thyroid disease**
- ☐ **Other** _____
  _____
  _____
  _____

Hematology/Oncology

- ☐ **Anemia**
- ☐ **Cancer**
- ☐ **Other** _____
  _____
  _____
  _____

Infectious

- ☐ **HIV**
- ☐ **STDs**
- ☐ **Tuberculosis**
- ☐ **Other** _____
  _____

Past surgeries:

Hospitalizations/Procedures:

OB & Pregnancy History:

Do you have any implantable devices? (Such as a pacemaker, joint replacement etc.)

Have you had any recent stays in a long term care facility? If yes, please explain.

Are you receiving hospice care? If yes, please explain.

Social History

Tobacco

- ☐ **Smoker**
- ☐ **Former**
- ☐ **Never smoked**

Alcohol

- ☐ **None**
- ☐ **Occasional**
- ☐ **Frequent**

Recreational Drugs

- ☐ **Yes**
- ☐ **No**

- ☐ **Other social**_____

Cardiovascular

- ☐ **Healthy meals**
- ☐ **Exercise**
- ☐ **Daily aspirin**

Sexual activity

- ☐ **Not sexually active**
- ☐ **Sexually active**

Birth gender

- ☐ **Male**
- ☐ **Female**

Family History

General

- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bleeding disorder**
- ☐ **COPD**
- ☐ **Heart attack**
- ☐ **Heart disease**
- ☐ **High cholesterol**
- ☐ **High blood pressure**
- ☐ **Stroke**
- ☐ **Other**_____

Cancer

- ☐ **Breast**
- ☐ **Colon**
- ☐ **Ovarian**
- ☐ **Prostate**
- ☐ **Uterine**
- ☐ **Other**_____

Who in your family was diagnosed?