DR. JACOB GERZENSHTEIN

Pharmacy ________________
____

PATIENT INFORMATION

Patient Name: ____

Mailing Address: ______________________________City:________________________

State: ______________________ Zip Code: _________________ Marital Status: S M W Sep D

DOB:__________________________SSN: ___________________________________

Home No.: ________________________ Cell phone: _____________________________

Email Adress:____

Employer Name: ____________________________ Ofc. No.: _______________________

Spouse's Name: ___________________________ Cell phone: _______________________

Spouse's Employer: _____________________________ Work No.: _______________________

____ Relationship: _______________________
Emergency Contact if different than spouse and phone number

How did you hear about Dr. Gerzenshtein? **Internet** **Billboard** **Magazine** **Friend** **Facebook** **Other**

INSURANCE INFORMATION

Primary insurance co. name: ______________________________________
ID # ______________________________ Group #__________________
Secondary insurance co. name: ____________________________________
ID # ______________________________ Group # _________________

We typically do not file insurance for our services. You are responsible for Dr. Gerzenshtein's fees in advance. Filing a claim with your insurance company will be your responsibility, unless arrangements have been made in advance with our office.

AUTHORIZATION TO RELEASE INFORMATION

If insurance is filed on my behalf, I hereby authorize the release of any and all medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I hereby authorize Dr. Jacob Gerzenshtein to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance co., be made directly to Dr. Jacob Gerzenshtein. I understand that the information I have reported with regard to insurance coverage and authorize assignee to release all information necessary to secure payment. This authorization may be revoked by either me or my insurance co., at any time in writing.

I have answered to the best of my ability and certify that all the enclosed information is true and correct.

I have been given, read, and fully understand Finer You PA and Dr. Gerzenshtein's HIPAA policy.

Patient's signature: _______________________________________ *Date:* ____________

Office staff providing HIPAA notice /Signature: ______________________________*Date:* ____________

DR. JACOB GERZENSHTEIN

GENERAL MEDICAL INFORMATION

Reason for today's visit: ____

Current medical conditions: ____

Present Medications: ____

____

Any Allergies to medications: ____

Other Physicians currently treating you: ____

List any surgeries/hospitalizations (including child birth): ______________________________

____

Females only: Are you pregnant? ___________ Planning a pregnancy? ___________ Or Nursing a child? _____________

Do you smoke? _______ yes _______ no No. of yrs. _________ How much per day? _________________________

Do you drink alcohol? ________ yes ________ no How much per day? (ounces/beers) _________________________

Height ________________ Weight _________________ Are you actively gaining/losing weight? __________________

Date of last Mammogram ________________________________ Normal _____________ Adnormal ______________

PERSONAL MEDICAL HISTORY

Have you ever had any of the following:

Chest pain/pressure/tightening	____	Asthma	____
Hypertension	____	Dizzy spells	____
Heart Attack	____	Cancer	____
Stroke	____	Diabetes	____
Headaches	____	Arthritis	____
Glaucoma	____	Problems with anesthesia	____
Allergies	____	Motion sickness	____
Depression	____	Hemorrhoids	____
Blood in stool	____	Kidney disease	____
Shortness of breath	____	TB/lung disorder	____
Hepatitis	____	Ulcers	____
Cataracts	____	Digestive problems	____
Frequent Urinary Infections	____	History of street drugs	____
HIV/Aids related exposure	____	Cold sores	____
Bleeding tendencies	____	Accutane	____