PATIENT'S INFORMATION

Last Name _____ First Name _____

Date of Birth _____ Social Security Number _____ Male ☐ Female ☐

Address:

_____ APT # _____
Street

_____ _____ _____
City State Zip Code

Home Phone Number: _____ **Cell Phone Number:** _____

Email Address: _____

Emergency Contact: Name _____

Relationship _____

Phone number _____

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Referring Physician _____ **Phone Number:** _____

INSURANCE:

Primary	Secondary
Insurance company name_____	insurance company name_____
ID Number _____	ID Number _____

IF SUBSCRIBER IS OTHER THAN SELF – COMPLETE THE FOLLOWING:

Subscriber's name _____	Subscriber's name _____
Subscriber's date of birth _____	Subscriber's date of birth _____

AUTHORIZATION INFORMATION (ASSIGNMENT OF BENEFITS)

I hereby assign to _____ any insurance of other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under by "Insurance", I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice all "Insurance" payments that I receive for services rendered to me immediately upon receipt and / or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

Signature _____ **Date** _____

FOR RELEASE OF INFORMATION

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPAA Notice of Privacy Practice" information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature _____ **Date** _____

SIGNATURE ON FILE
FOR ELECTRONIC SUBMISSIONS

BORIS L. BENTSIANOV M.D.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO DR. _____ FOR SERVICES FURNISHED TO ME BY THE PROVIDER. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CO-PAY AND/OR DEDUCTIBLE PAYMENTS.

I AUTHORIZED ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE OR RELATED SERVICES.

PATIENT'S NAME: _____
(PRINT)

PATIENT'S SIGNATURE: _____

DATE _____

WITNESS _____

BORIS L. BENTSIANOV M.D.

I hereby acknowledge that the Notice of Privacy Practice has been explained to me and I have received a paper copy of the Notice.

Patient Signature Date

Print Patient Name

Witness Date

Dr. Bentsianov -- BROOKLYN EYE AND EAR MEDICAL P.C.

Patient Name: _____ **Today's Date:** _____
Referring Doctor: _____ **Primary Care Provider:** _____

Chief Complaint (reason for your visit): _____

MEDICAL PROBLEMS (check all that apply):

- ☐ High Blood Pressure
- ☐ Heart disease/ Heart attack x _____
- ☐ Stroke / TIA (please circle)
- ☐ Diabetes (please circle) Insulin/Non-insulin
- ☐ Asthma
- ☐ COPD/Emphysema/Black Lung
- ☐ High Cholesterol
- ☐ Arthritis
- ☐ Pregnant
- ☐ Cancer- type: _____
- ☐ Radiation therapy/chemotherapy (please circle)
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Sexually Transmitted Disease (i.e. syphilis)
- ☐ Bleeding Disorder
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

SURGICAL HISTORY:

Type and reason	Hospital	Surgeon	Date

FAMILY HISTORY:

List any diseases that run in your family: _____
(circle) Heart disease Diabetes Asthma Thyroid disease Bleeding disorder Cancer (type: _____)

SOCIAL HISTORY:

Do you use tobacco products? ___No ___Yes: (circle) Cigarette Cigar Pipe Snuff Chew Dip
How much per day? _____For how many years?_____ If you've stopped, when did you stop?_____
Does anyone around you smoke at home? ___No ___Yes

Do you use alcohol? ___No ___Yes: How much per day / week? _____
Have you ever used cocaine / crystal meth? ___No ___Yes
Have you ever used IV drugs? ____No ____Yes

Occupation:_____
Who do you live with? _____ Children? _____
Pets (inside / outside) _____

ALLERGIES:

Medications: _____ Seasonal allergies: _____
Foods: _____ Have you ever had allergy testing? Yes / No(circle)

MEDICATIONS: (Current prescription and non-prescription medication, dose, frequency)

_____
_____
_____
_____
_____

Do you take aspirin or any blood thinning medication? ___No___Yes, specify:_____

DID YOU HAVE ANY RECENT HEARING TESTS OR IMAGING STUDIES? CAT scan MRI ultrasound of thyroid

Dr. Bentsianov – BROOKLYN EYE AND EAR MEDICAL P.C.

Patient Name: _____

Constitutional	No	Yes
Weakness / fatigue	___	___
Weight loss	___	___
Fever / Chills	___	___
Pregnant	___	___
Ears		
Hearing loss	___	___
Ear pain	___	___
Ear infections	___	___
Vertigo	___	___
Ringing in ears	___	___
Meniere's disease	___	___
Nose		
Nasal congestion	___	___
Drainage / color	___	___
Decreased taste / smell	___	___
Postnasal drip	___	___
Facial / sinus pain	___	___
Previous injury to nose	___	___
Throat / mouth		
Tonsillitis, frequent	___	___
Bad breath	___	___
Eyes		
Recent change in vision	___	___
Glasses	___	___
Contacts	___	___
Glaucoma	___	___
Blindness	___	___
Endocrine		
Thyroid problems	___	___
Diabetes / blood sugar	___	___
Respiratory		
Cough	___	___
Cough up blood	___	___
Breathing difficulty	___	___
Lung problems	___	___
Wheezing / asthma	___	___
Tuberculosis	___	___
Abnormal chest X-ray	___	___
Hemo / lymphatic		
Swollen glands	___	___
Bleeding disorder	___	___
Cancer	___	___

Cardiothoracic	No	Yes
Heart attack	___	___
Heart failure	___	___
High blood pressure	___	___
Irregular heart beat	___	___
Vascular		
Blood clots	___	___
Gastrointestinal		
Indigestion / heartburn	___	___
Problems swallowing	___	___
Liver disease	___	___
Genitourinary		
Kidney / bladder disease	___	___
Dialysis	___	___
Musculoskeletal		
Injury to facial bones	___	___
Arthritis	___	___
Joint / bone disease	___	___
Skin		
Skin changes	___	___
Rashes	___	___
Lesions	___	___
Neurological		
Headaches	___	___
Dizziness	___	___
Stroke	___	___
Seizures	___	___
Psychiatric		
Anxiety attacks	___	___
Depression	___	___
Memory loss	___	___

_____

Patient signature or Guardian signature for minors

_____

Print Name of Guardian and Relationship to Patient

_____

Physician signature Date