Babylon Medical Practice

350 West Main Street ‣ Babylon, NY 11702
Telephone: (631) 661-2277 ‣ FAX: (631) 669-2190
Visit our new website at **BabylonMedicalPractice.com**

Section 1: Patient			
Last Name:	First Name:		M.I.:
Street Address:	City:		
Address Line 2:	State:	Zip:	
Telephone Number:	Cell Phone Number:		
Email Address:	Social Security Number:		
D.O.B.: ________ / ________ / ______________	Age:	Gender: Male / Female	
Select One: Single Married Widowed Separated Divorced			

Section 2: Emergency Contact			
Last Name:	First Name:		M.I.:
Street Address:	City:		
Address Line 2:	State:	Zip:	
Telephone Number:	Cell Phone Number:		
Relationship to Patient:			

Section 3: Occupation		
Occupation Title:		
Occupation Employer:	Telephone Number:	
Street Address:	City:	
Address Line 2:	State:	Zip:
Does this occupation expose you to the following: Stress Heavy Lifting Hazardous Substances Other N/A		
If Other, Please Explain:		

Section 4A: Insured Person

If you are the Insured Person, circle N/A and continue to Section 4B. If you are NOT the Insured Person, fill out their information below.			N/A
Last Name:	First Name:		M.I.:
Street Address:	City:		
Address Line 2:	State:	Zip:	
Telephone Number:	SSN:		
D.O.B.: ________ / _______ / _______________	Relationship to Patient:		

Section 4B: Primary Insurance

Insurance Company Name:		
ID #:	Plan:	Group:
Subscriber Name:	Subscriber Employer:	

Section 4C: Secondary Insurance

Insurance Company Name:		Insurance Company Telephone:
ID #:	Plan:	Group:
Subscriber Name:	DOB:	Subscriber Employer:

Section 5: Pharmacy

Pharmacy Name:	Telephone Number:

Section 6: Current and Historical Medical Information

Describe your Chief Complaint in the Section Below: N/A

____

____

____

Describe your Medical History (including any serious illnesses or operations):

Section 6 cont.: Current and Historical Medical Information

Describe your Family Medical History:
Circle N/A if you do not know your Family Medical History N/A

Mother:	N/A
Father:	N/A
Siblings:	N/A
Grandparents:	N/A

Circle any of the following that you use:

Caffeine Drugs Tobacco Other

Explain your usage of the above:

Section 7A: Medications

What Medications are you currently taking?

Section 7B: Allergies to Medications and other Substances

WHAT ARE YOUR ALLERGIES TO MEDICATIONS AND OTHER SUBSTANCES? N/A

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____

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____

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____

SECTION 8: SYMPTOMS

Check (✓) symptoms you currently have or have had in the past year:

GENERAL
- ❑ Chills
- ❑ Depression/Nervousness
- ❑ Dizziness/Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Numbness
- ❑ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- Hips
- Legs
- Neck
- Shoulders

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

GASTROINTESTINAL
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

CARDIOVASCULAR
- ❑ Chest pain
- ❑ High/Low blood pressure
- ❑ Irregular/Rapid heart beat
- ❑ Poor circulation
- ❑ Swelling of ankles
- ❑ Varicose veins

EYE, EAR, NOSE, THROAT
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache/Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision - Flashes/Halos

SKIN
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching/Rash
- ❑ Change in moles
- ❑ Scars
- ❑ Sores that won't heal

MEN only
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

WOMEN only
- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period __________

Date of last Pap Smear ____________

Have you had a mammogram __________

Are you pregnant? _______

Number of children _______

Check (✓) conditions you have or have had in the past:

- ❑ AIDS
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal Diseases

PAIN	NUMBNESS / TINGLING	NUMBNESS / WEAKNESS
☐ NECK	☐ NECK	☐ NECK
☐ SHOULDER(S)	☐ SHOULDER(S)	☐ SHOULDER(S)
☐ ARM(S)	☐ ARM(S)	☐ ARM(S)
☐ WRIST(S)	☐ WRIST(S)	☐ WRIST(S)
☐ HAND(S)	☐ HAND(S)	☐ HAND(S)

☐ Fingers	☐ Fingers	☐ Fingers
☐ Lower Back	☐ Lower Back	☐ Lower Back
☐ Leg(s)	☐ Leg(s)	☐ Leg(s)
☐ Knee(s)	☐ Knee(s)	☐ Knee(s)
☐ Feet	☐ Feet	☐ Feet
☐ Toe(s)	☐ Toe(s)	☐ Toe(s)

Are You a Diabetic? Yes No

Have you noticed loss of strength in any particular area? Yes No

Do you have any additional symptoms not covered by the above? If so, please explain:

____

____

____

____

____

Section 9: Environmental Allergies

How long have you had environmental allergy symptoms?
If you do not have these symptoms, circle N/A and continue to Section 10. N/A

SYMPTOMS: (Please check all that apply)

NOSE:
☐ Frequent sneezing
☐ Runny nose
☐ Congestion/blockage
☐ Itching
☐ Nose bleeds
☐ Loss of smell
☐ Nasal polyps
☐ Other:

SINUSES:
☐ Frequent infections
☐ Pressure in facial bones
☐ Pressure around eyes
☐ Throat drainage
☐ Other:

EYES:
☐ Itching/tearing
☐ Burning
☐ Redness
☐ Swelling of eye lids
☐ Dark circles
☐ Infections
☐ Other:

EARS:
☐ Pain
☐ Itching
☐ Plugging/popping
☐ Loss of hearing
☐ Other:

LUNGS:
☐ Asthma
☐ Wheezing
☐ Cough - daytime
☐ Cough - nighttime
☐ Productive cough
☐ Dry cough
☐ Wheeze with exercise
☐ Other:

SKIN:
☐ Contact rash
☐ Eczema
☐ Hives
☐ Itching
☐ Other:

HEADACHES:
☐ Sinus
☐ Tension
☐ Migraines
☐ Medications that help (please list)
____
____
☐ Other:

GASTROINTESTINAL:
☐ Nausea/vomiting
☐ Diarrhea
☐ Constipation
☐ Other:

TRIGGERS OF YOUR SYMPTOMS:

During which months do you have symptoms? (Please check ll that apply)
☐ Spring ☐ Summer ☐ Fall ☐ Winter

Which of the following exposures seem to worsen your symptoms? (Please check all that apply)

☐ Yard work	☐ Cats	☐ Dry weather	☐ News print
☐ House work	☐ Dogs	☐ Wet weather	☐ Mold/mildew
☐ Mowing lawns	☐ Other Animals	☐ Hot weather	☐ Foods: (list below)
☐ Barns	☐ Aerosols	☐ Humidity	____________________
☐ Vacuuming	☐ Perfumes	☐ Windy day	____________________
☐ Stress	☐ Smoke	☐ Out of doors	

HAVE YOU HAD A PREVIOUS ALLERGY EVALUATION? ☐ YES ☐ NO

DID YOU HAVE ALLERGY SKIN TESTING?	
DID YOU RECEIVE IMMUNOTHERAPY (ALLERGY SHOTS)?	
DID YOUR SYMPTOMS IMPROVE DURING IMMUNOTHERAPY?	
DID YOU EXPERIENCE ANY ADVERSE REACTIONS?	
WHERE WERE YOU BORN AND RAISED?	
HOW LONG HAVE YOU LIVED IN THE NORTHEAST?	
HOW LONG HAVE YOU LIVED IN YOUR CURRENT HOME?	
HOW OLD IS YOUR HOME?	
DATE OF LAST DOSE OF ALLERGY MEDICATION:	

SECTION 10: SLEEP HEALTH

HAVE YOU BEEN TOLD YOU SNORE LOUDLY?	☐ YES	☐ NO	I WANT TO LEARN MORE ABOUT HOW SLEEP PROBLEMS AFFECT MY HEALTH.	☐ YES	☐ NO
HAVE YOU BEEN TOLD THAT YOU STOP BREATHING AT NIGHT?	☐ YES	☐ NO	PHYSICIAN USE ONLY:		
ARE YOU OFTEN TIRED DURING THE DAY?	☐ YES	☐ NO	☐ REVIEWED, ORDER SLEEP STUDY, TITRATION AND TREATMENT IF POSITIVE FOR OSA		
IS CONTROLLING YOUR BLOOD PRESSURE DIFFICULT?	☐ YES	☐ NO	FAX TO 888 539-3001		
DO YOU AWAKEN WITH SHORTNESS OF BREATH?	☐ YES	☐ NO	☐ REVIEWED, DO NOT ORDER SLEEP STUDY; PLACE IN CHART.		
DO YOU FALL ASLEEP WHILE READING OR WATCHING TV?	☐ YES	☐ NO	PHYSICIAN SIGNATURE: ______________________		
DO YOU EVER HAVE TROUBLE CONCENTRATING?	☐ YES	☐ NO	PATIENT NAME: ______________________		
HAVE YOU BEEN DIAGNOSED WITH SLEEP APNEA?	☐ YES	☐ NO	PATIENT PHONE NUMBER: ______________________		

SECTION 11: SIGNATURE(S)

SIGNATURES:
I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____________________________ Date ________________ Reviewed by ______________________

Authorization to Release Information and Assignment of Benefits
I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original
.

Date: ____________________ Signature: ____________________________________

I hereby authorize Dr. Howard M. Hertz to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. Hertz (or to the party who accepts assignment).
I certify the information I have reported with regard to my insurance coverage is correct. In the event that the insurance information provided is incorrect, invalid, or Dr. Howard M. Hertz is not listed as my primary care physician, I understand that I will then assume responsibility for any unpaid balances.
I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date: ____________________ Signature: ____________________________________

Authorization Form, Howard M. Hertz, M.D., P.C., Jared A. Hertz, D.O.

I ___________________________________, hereby authorize Howard M. Hertz M.D., P.C. and/or Jared A. Hertz, D.O., to use and disclose my protected health information pursuant to the Notice of Privacy Practices that are posted in the office at 350 West Main Street, Babylon, NY. I have also been given the opportunity to review and/or receive a copy of these Privacy Practices.
This authorization shall be in force and effect until such time that I give notification requesting the termination of the authorization.
I understand that I have the right to revoke this authorization. In writing, at any time by sending such written notification to the attention of Howard M. Hertz, M.D., P.C., at 350 West Main Street, Babylon, NY, 11702. I understand that a revocation is not effective to the extent that Howard M. Hertz, M.D., P.C., and/or Jared A. Hertz, D.O. has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal or state law.
Howard M. Hertz. M.D., P.C. and/or Jared H. Hertz, D.O. will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under Federal law (or state law to the extent the state law provides greater access rights), and/or refuse to sign this authorization.

Signature of Patient or Personal Representative ______________________________________ Date _________________________________

Name of Patient or Personal Representative ____

Description of Personal Representative's Authority ____