Bradley R. Wasserman, MD

PATIENT INFORMATION SHEET

Name: _____ Age: ____ Birth Date: _ _ / _ _ / _ _ SS#:_____

ADDRESS

Home: _____
Apt #: _____
City/State/Zip: _____
Occupation: _____
Email: _____
Employer: _____
Work Address: _____

CONTACT NUMBERS

Home Phone: (_ _ _) _ _ _-_ _ _ _
Work Phone: (_ _ _) _ _ _-_ _ _ _
Cell Phone: (_ _ _) _ _ _-_ _ _ _
Fax: (_ _ _) _ _ _-_ _ _ _

Emergency Contact:

Name: _____
Phone: _____
Relationship: _____

Marital Status: _____

REFERRAL

Referral Source: _____
Primary MD: _____
Address: _____
_____
Phone: _____

INFORMATION INSURANCE INFORMATION

Insurance Company: _____
Policy #: _____
Insured Name: _____
Relationship to Insured: _____
Insured SS#: _____
Insured DOB: _____

INJURY INFORMATION

Date of Injury: _ _ / _ _ / _ _ ☐ Work Injury ☐ Auto Accident ☐ Law Suit

Body Part Injured: _____ What happened: _____

Type of Pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Constant ☐ Radiating

Intensity of Pain: 0 1 2 3 4 5 6 7 8 9 10
(Low Pain *Moderate Pain* *Intense Pain)*

What makes it worse? _____

What makes it better? _____

Previous treatment for this problem? _____

MEDICAL INFORMATION

Height: _____ Weight: _____

Past Medical History: _____
(Example: Diabetes, Hypertension, Heart Disease) _____
Past Surgical History: _____
_____
Medications: _____

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Allergies to Medications: _____

Social History

Former or present smoker?	☐	No	☐	Yes *# of Packs a day*_____ *How Long* _____
Do you drink alcohol?	☐	No	☐	Yes *frequency* _____
Former or present drug use?	☐	No	☐	Yes_____
Do you play any sports?	☐	No	☐	Yes_____

Review of Symptoms

Do you have now, or have you had, any of the following?

Fevers/Chills	☐	Yes	☐	No	Shortness of breath	☐	Yes	☐ No
Nausea/Vomiting	☐	Yes	☐	No	Asthma	☐	Yes	☐ No
Abdominal Pain	☐	Yes	☐	No	Emphysema	☐	Yes	☐ No
Diarrhea	☐	Yes	☐	No	Numbness	☐	Yes	☐ No
Constipation	☐	Yes	☐	No	Tingling	☐	Yes	☐ No
Incontinence	☐	Yes	☐	No	Seizures	☐	Yes	☐ No
Weakness	☐	Yes	☐	No	Headaches	☐	Yes	☐ No
Chest Pain	☐	Yes	☐	No	Morning Stiffness	☐	Yes	☐ No
Diabetes	☐	Yes	☐	No	Joint Swelling	☐	Yes	☐ No
Kidney disease	☐	Yes	☐	No	HIV	☐	Yes	☐ No
Thyroid Disease	☐	Yes	☐	No	Herpes	☐	Yes	☐ No
Blood Clots	☐	Yes	☐	No	Sickle Cell	☐	Yes	☐ No
Rashes	☐	Yes	☐	No	Infection	☐	Yes	☐ No
Cancer	☐	Yes	☐	No	Depression	☐	Yes	☐ No

Is there anything else you would like your doctor to know?

_____

_____

_____

Family History

1. Family History of arthritis or other rheumatologic diseases? Yes No

If yes, please list:

_____

_____

2. Family history of bleeding or clotting disorders? Yes No

If yes, please explain:

_____

_____

3. Family history of heart disease or sudden death? Yes No

If yes, please explain:

_____

_____

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Advise if any of the family members listed below have/had any of the conditions listed above in the "Review of Systems" section

Mother:

_____

Father:

_____

Grandparents:

Siblings:

_____

Pharmacy Information

At this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today may be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions. In addition, when you run out of refills on your medication, the pharmacist can now electronically send renewal requests to this office for approval.
**Note: Controlled medications are not eligible for e-prescribing.

Preferred Pharmacy
Name of Pharmacy _____
Address_____
City_____
State_____
Zip Code_____
Phone Number_____
Fax Number_____
Assignment and Release_____

I, the undersigned have insurance coverage with_____ and assign directly to Dr. Wasserman all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature:_____ Date: ____/____/ _____

Guarantor Signature (If other than patient): _____ Date: ____/____/_____