Adam J. Schneider, M.D. P.C.

Board Certified Neurology
Electromyography
380 North Broadway, Suite 307
Jericho, NY 11753

TODAY'S DATE: _____ SOC SEC #: _____

PATIENT'S DATE OF BIRTH: _____ AGE: _____

NAME: _____
Last First M.I.

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PREFERRED PHONE: ( ) _____

ALTERNATE PHONE: ( ) _____

DO YOU WORK FULL TIME OR PART TIME? Y / N ARE YOU A FULL TIME STUDENT: Y / N

OCCUPATION:_____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

_____

PATIENT'S SEX: MALE / FEMALE / _____ PREFERRED PRONOUNS: _____

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / SEPARATED / WIDOWED / PARTNERED

WHOM MAY WE THANK FOR REFERRING YOU TO US: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

ADDRESS: _____

_____

PHONE: _____

IN CASE OF ANY EMERGENCY WHO SHOULD BE NOTIFIED? _____

PHONE/CELL NUMBER OF ABOVE PERSON: ( ) _____

Adam J. Schneider, M.D. P.C.

PLEASE COMPLETE ALL QUESTIONS PERTAINING TO YOUR INSURANCES. THANK YOU!

PRIMARY INSURANCE: _____

ID #: _____

INSURED 'S SOC SEC #: _____

GROUP/ POLICY: _____

INSURED'S DATE OF BIRTH: _____

INSURED'S NAME: _____

PATIENT'S RELATIONSHIP TO INSURED: _____

INSURED'S EMPLOYER'S NAME: _____

ADDRESS: _____

SECONDARY INSURANCE: _____

ID #: _____

INSURED 'S SOC SEC #: _____

GROUP / POLICY: _____

INSURED'S DATE OF BIRTH: _____

INSURED'S NAME: _____

PATIENT'S RELATIONSHIP TO INSURED: _____

INSURED'S EMPLOYER'S NAME: _____

ADDRESS: _____

Adam J. Schneider, M.D. P.C.

Dr Adam Schneider may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment of services rendered.

SIGNATURE: _____

PRINT NAME: _____

RELATIONSHIP TO PATIENT: _____

In accordance with the HIPAA privacy policy Dr. Schneider' s office may discuss my medical condition with the following persons:

_____

1. name relationship telephone #

_____

2. name relationship telephone #

_____

3. name relationship telephone #

In the event we are unable to reach you, may we leave a message on your home or cell phone recorder? YES / NO

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ASSIGNMENT AND RELEASE OF INFORMATION:

I HEREBY CERTIFY THAT l, AND/OR MY DEPENDENTS, HAVE INSURANCE COVERAGE WITH THE AFOREMENTIONED INSURANCE COMPANIES AND ASSIGN ALL BENEFITS DIRECTLY TO ADAM J. SCHNEIDER, M.D., P.C. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL MIY CHARGES IF DENIED BY THE AFORENMENTIONED INSURANCE COMPANIES. I ALSO ACKNOWLEDGE THAT IT IS MY RESPONSBILITY TO INFORM THE OFFICE OF ANY CHANGES IN MY INSURANCE COVERAGE. I AUTHORIZE THE USE OF MY SIGNATURE FOR ALL INSURANCE SUBMISSIONS.

IF MY ACCOUNT IS DELINQUENT ADMINISTRATIVE FEES AND OR ATTORNEY FEES MAY BE ADDED TO THE BALANCE,

PATIENT'S NAME: _____

SIGNATURE: _____

Adam J. Schneider, M.D., P.C.

Board Certified Neurology
380 North Broadway—Suite 307
Jericho, NY 11753
Telephone: 516-338-2908 Facsimile: 516-333-6160

Name: _____ DOB: _____

Medications/Vitamins/Supplements List

Name	Dosage

Signature: _____ Date: _____