Jeffrey Jacobson, MD

WP HOSPITAL physician associates

2345 Boston Post Road
Larchmont, NY 10538
99 Business Park Drive
Armonk, NY 10504
914 421-0123

Patient Demographics

Patient's Last Name _____ First Name _____ Middle Initial _____

SSN _____ Date of Birth _____ Age _____ Gender F M

Address _____ Apt. # _____ City _____ State _____ Zip _____

Race:
☐ American Indian/Alaska Native ☐ Asian ☐ White
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer Preferred Language: _____

Marital Status: ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Separated Student Status ☐FT ☐PT

Home Phone _____ Day Phone _____

Email Address _____ Cell Phone _____

Employer _____ Occupation _____ ☐Retired?

Employer Address _____

Emergency Contact _____/_____ Phone _____
Name Relationship

Primary Care Physician Name: _____ Phone:_____

Referring Physician Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Primary Insurance Coverage: _____

Policy Holder Name: _____ SSN:_____ DOB:_____

Secondary Insurance Coverage: _____

Policy Holder Name: _____ SSN: _____ DOB: _____

This visit is covered by: ☐ No Fault Insurance ☐ Workers' Compensation _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature _____ Date_____
Responsible Party Name _____ Relationship _____

Patient History Form

Name: _____ **Date of Birth:** _____

Reason for Visit:

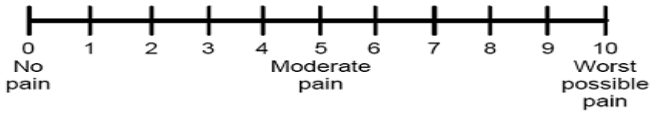
_____

_____

Please List All Current Medications			☐ **Not Currently Taking Any Medications**		
Medication Name	**Dosage**	**How Often Taking**	**Medication Name**	**Dosage**	**How Often Taking**
Vitamins/ Supplements	**Dosage**	**How Often Taking**	**Vitamins/ Supplements**		**How Often Taking**

Allergies (e.g. medication, latex, egg)		☐ **No Known Allergies**	
Allergen	Type of Reaction	Allergen	Type of Reaction

Please indicate (circle) your current pain scale in relation to your current condition:



How would you prefer that we contact you?

☐ Home Phone ☐ Cell Phone ☐ Work/Day Phone ☐ Patient Portal ☐ Home Address

☐ Other _____

Patient Signature: _____ Date: _____

Patient Representative Signature:_____ Relationship: _____

Jeffrey Jacobson, MD

WP HOSPITAL physician associates

2345 Boston Post Road
Larchmont, NY 10538
99 Business Park Drive
Armonk, NY 10504
914 421-0123

NAME: _____ AGE: _____ DOB: _____ DATE: _____

Reason for today's visit: _____

MEDICAL CONDITIONS (circle all that apply):

Blood Pressure (High / Low)	Thyroid Disease	Diabetes
Stroke	Cholesterol	Heart Attack
HIV / AIDS	Hepatitis	

List any prior surgeries (please include the year of surgery)

_____

_____

_____

Have you ever had general anesthesia? NO YES
If YES were there problems? NO YES

FAMILY HISTORY

Member of Family	Alive	Deceased	Age	Health status or cause of death
Father	A	D	____	_____
Mother	A	D	____	_____
Sister (s)	A	D	____	_____
Brothers (s)	A	D	____	_____

Any other family illness that may be pertinent _____

SOCIAL HISTORY

History of Substance Abuse NO YES

I currently drink alcohol / beer Never Daily 1 – 2 x /wk 1 – 2 x /mo 1 – 2 x/yr

I smoke tobacco products NO YES I quit smoking _____
I currently smoke _____ packs / day for the past _____ years
Caffeine NO YES
Type Coffee Chocolate Energy Drinks Soda Tea Tablets
Amount Daily _____

Have you had any falls in the last year? ☐ Yes ☐ No If Yes, please state the number of falls: _____

Did the fall(s) result in injury? ☐ Yes ☐ No Do you use any assistive devices? ☐ Yes ☐ No

Have you recently felt physically or emotionally harmed? ☐ Yes ☐ No

Jeffrey Jacobson, MD

WP HOSPITAL physician associates

2345 Boston Post Road
Larchmont, NY 10538
99 Business Park Drive
Armonk, NY 10504
914 421-0123

NAME: _____ DOB: _____

Allergies to Medications / Food ☐ None

_____

_____

Height: _____ Weight: _____

Dominate Hand (circle) Right Left Ambidextrous

Is it possible you are currently pregnant (circle)?: Yes No

REVIEW OF SYSTEMS:
Are you currently having or have you had problems with?:

	Circle		Describe all yes responses
Chills, Fever, Sweats	Y	N	_____
Weakness	Y	N	_____
Weight (gain/loss)	Y	N	_____
Eyes	Y	N	_____
Headaches	Y	N	_____
Ear problems/ Hearing	Y	N	_____ _____
Chest Pain	Y	N	_____
Bleeding problems	Y	N	_____
Cough	Y	N	_____
Asthma, COPD	Y	N	_____
Difficulty Breathing	Y	N	_____
Skin issues	Y	N	_____
Cancer	Y	N	_____
Heart Problems	Y	N	_____
Seizures /Tremors	Y	N	_____
Fainting / Blackout	Y	N	_____
Bleeding / Bruising	Y	N	_____
Urination Issues	Y	N	_____
Psychological Problems	Y	N	_____
Hot / Cold Intolerance	Y	N	_____
Difficulty walking	Y	N	_____
Numbness / Tingling	Y	N	_____
Liver Disease	Y	N	_____
Thyroid Disease	Y	N	_____
Arthritis / Gout	Y	N	_____
AIDS (may leave blank)	Y	N	_____
Hepatitis	Y	N	_____
Digestion Disorder	Y	N	_____

Above information was reviewed and any addition / changes to the form were noted.

_____ _____

PROVIDERS SIGNATURE DATE

White Plains Hospital
Exceptional, every day.

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization for release of information by

WHITE PLAINS HOSPITAL

I hereby authorize and direct the above named Medical facility, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

_____
Signature of Patient or Authorized Representative

I hereby assign, transfer and set over to the above named Medical facility sufficient monies and/or benefits to which I may be entitled form governmental agencies, insurances carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said hospital or medical facility.

_____
Signature of Patient or Authorized Representative

I, _____, give consent and authorize the hospital and its employees, and the hospital agents or contracted parties (including debt collection agencies) to contact me and use an automated telephone dialing system to call my cellular or mobile phone number regarding all matters relating to the services and care provided, including payment.

_____
Signature of Patient or Authorized Representative

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Jeffrey Jacobson, MD

WP HOSPITAL physician associates

2345 Boston Post Road
Larchmont, NY 10538
99 Business Park Drive
Armonk, NY 10504
914 421-0123

WORKERS COMPENSATION INTAKE FORM

I hereby authorize payment directly to WHITE PLAINS HOSPITAL for services rendered relating to an accident/injury covered under Workers Compensation insurance benefits.

I hereby authorize the provider of these services to release any medical records relating to my claims to my insurer liable for payment of such claim.

In the event the provider's charges are outstanding and / or fail to file an application for benefits under New York State Insurance law, I understand that I am personally responsible for the payment of the charges related to my claim.

Patient's Name _____ Date of Birth _____

Address: _____ Phone # _____

Is this visit the result of an accident? At work ☐

Automobile ☐

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____

EMPLOYER NAME: _____ Phone # _____

EMPLOYER ADDRESS: _____

How did accident / injury occur? _____

Body Parts established in WC Case: _____

Workers Comp Board Number _____ Carrier Case # _____

Address for insurance claims (not the agent): _____

Insurance Co Address: _____

Adjuster's Name & Phone # _____

Adjusters Fax # _____

Attorney's Name & Phone #: _____

PATIENT SIGNATURE: _____ DATE: _____

PLEASE NOTE THAT FAILURE TO PROVIDE US WITH THE APPROPRIATE CLAIM INFORMATION AND OR FAILURE TO FILE A CLAIM WITH YOUR INSURER WILL NECESSITATE US REQUIRING PAYMENT FROM YOU AT THE TIME OF SERVICE.

Jeffrey Jacobson, MD

WP HOSPITAL physician associates

2345 Boston Post Road
Larchmont, NY 10538
99 Business Park Drive
Armonk, NY 10504
914 421-0123

NO FAULT INTAKE FORM

I hereby authorize payment directly to WHITE PLAINS HOSPITAL for services rendered relating to an accident/injury covered under NO FAULT insurance benefits.

I hereby authorize the provider of these services to release any medical records relating to my claims to my insurer liable for payment of such claim.

In the event the provider's charges are outstanding and / or fail to file an application for benefits under NO FAULT law, I understand that I am personally responsible for the payment of the charges related to my claim.

Patient's Name _____ Date of Birth _____

Address: _____ Phone # _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____AM / PM

How did accident occur? _____

CLAIM # _____ POLICY # _____

Address for insurance claims (not the agent): _____

Insurance Co Address: _____

Agent's Name & Phone # _____

Agent's Fax # _____

PATIENT SIGNATURE: _____ DATE: _____

PLEASE NOTE THAT FAILURE TO PROVIDE US WITH THE APPROPRIATE CLAIM INFORMATION AND OR FAILURE TO FILE A CLAIM WITH YOUR INSURER WILL NECESSITATE US REQUIRING PAYMENT FROM YOU AT THE TIME OF SERVICE.

Jeffrey Jacobson, MD

WP HOSPITAL physician associates

2345 Boston Post Road
Larchmont, NY 10538
99 Business Park Drive
Armonk, NY 10504
914 421-0123

DISCLOSURE AUTHORIZATION

PATIENT NAME (print) : _____ DATE OF BIRTH: _____

I authorize White Plains Physician Associates to disclose the following to the individual(s) listed below:

( ) Speak to provider on my behalf

( ) Pick up / discuss labs, notes or prescriptions, etc. from office

( ) Other _____

( ) All of the above

Restrictions (if any):

_____

_____

Name: _____ Expiration Date: _____

Name: _____ Expiration Date: _____

Name: _____ Expiration Date: _____

_____ _____

Patient Signature Date

Signature of Patient or Authorized Representative