

Dr. Benzion Benatar, M.D.
Dr. David Benatar, M.D.
Bethany Sumner, P.A.C.

2631 Merrick Rd.
Bellmore, NY 11710
(516) 785-5350

PATIENT REGISTRATION FORM

Name _____ Date of Birth _____ Age _____ M F
Social Security# _____ Marital Status _____ Phone# _____
Address _____ Town _____ State _____ Zip _____
Employer _____ Occupation _____
Employer Address _____ Town _____ State _____ Zip _____
Employer Phone # _____ May we contact you at work? Yes No
Primary Care Physician _____ Phone # _____ Fax # _____
Primary Care Address _____ Town _____ State _____ Zip _____

Date of Injury _____

Is this injury the result of an Auto Accident? Yes No

Is this injury the result of a Work Accident? Yes No

If this injury is the result of an accident, will you be utilizing an attorney?

Please make sure our staff has given you the appropriate paperwork pertaining to your Injury.

Primary Insurance _____ Id# _____ Group# _____
Insurance Address _____ Copay \$ _____
Policyholder _____ Relationship to Patient _____
Social Security # _____ Date of Birth _____ Age _____ M F

Secondary Insurance _____ Id# _____ Group# _____
Insurance Address _____ Copay \$ _____
Policyholder _____ Relationship to Patient _____
Social Security # _____ Date of Birth _____ Age _____ M F

I authorize the release of any information, including the diagnosis and medical records of any treatment or examination rendered to my child or me during the period of such care to third party payers and/or health practitioners.

I authorize and request my Insurance Company to pay directly to the doctor any benefits payable to me.

In the event that the provider's charges are outstanding or I fail to provide the office with the correct insurance information, I understand that I am personally responsible for payment of the provider's charges.

I have read the above information and it is true and accurate.

Signature _____ Date _____

Dr. Benzion Benatar, M.D.
 Dr. David Benatar, M.D.
 Bethany Sumner, P.A.C.

2631 Merrick Rd.
 Bellmore, NY 11710
 (516) 785-5350

Name _____ Date of Birth _____ Date _____

Height _____ Weight _____

History of Present Illness:

Chief Complaint: _____

Referring physician for current problem? _____

How did this occur? _____

How severe is the pain/problem? _____

Have you been treated for this problem before? _____

If so when? _____

Do you have any allergies? _____

What medications are you taking? _____

Past Medical History

Diabetes	Yes	No	Arthritis/Gout	Yes	No
Hypertension	Yes	No	Convulsions	Yes	No
Cancer	Yes	No	Bleeding Tendency	Yes	No
Stroke	Yes	No	Acute Infection	Yes	No
Heart Trouble	Yes	No	Hereditary Defects	Yes	No
Hepatitis	Yes	No	Kidney problems	Yes	No

Have you had previous Hospitalizations/ Surgeries / or Serious Injuries? _____

Review of Symptoms: check if denied/ circle symptoms

	Denies	Symptoms
Neurological		Headache Syncope Dizziness Seizure Numbness Tingling Weakness
Eyes Ears Throat		Vision Change Hearing Change Tinnitus Smelling Change Congestion
Respiratory		Cough Wheezing Pain Asthma
Cardiovascular		Chest Pain Palpitations Irregular Heartbeat Murmur Edema
GI		Nausea Vomiting Constipation Diarrhea Bleeding Pain
GU		Incontinence Discharge Frequency Urgency Bleeding Pain
Musculoskeletal		Swelling Range of Motion change Pain
Skin		Rash Skin change Pain
Psych/Subst. Abuse		History of Treatment: Outpatient Inpatient months years

Social History:

Alcohol:	Never	Rarely	Moderate	Daily
Tobacco:	Never	Rarely	Moderate	Daily
Drugs:	Never	Rarely	Moderate	Daily

Family Medical History:

Relative	Age	Diseases	If Deceased, when
Father			
Mother			
Siblings			