Stephen G. Geiger, M.D.
Physical Medicine and Rehabilitation
Phone: 516-222-6824/ Fax: 516-222-7980

New Patient Registration and Demographics

Date: _____

Name: _____ Home Phone: _____
Work Phone: _____
Address: _____ Cell Phone: _____

City: _____State:___Zip:_____ Date of Birth: _____

Employer: _____ Soc. Sec. #: _____

Address: _____ Martial Status:_____Sex:_____
City: _____State:____Zip:_____ Ethnicity: _____Race:_____
Language: _____

Pharmacy Name/Address: _____
_____ Pharmacy Number: _____
City:_____State:____Zip:_____ **Drug Allergies**: _____

Insurance Information

Primary
Insurance Name: _____ **Policy Holder**: _____

ID #: _____ Group #: _____

Address: _____ Policy Holder DOB: _____
City:_____State:_____Zip_____
Insurance Phone: _____ **Relationship to Patient**: _____

Secondary
Insurance Name: _____ **Policy Holder**: _____

ID #: _____ Group #: _____

Address: _____ Policy Holder DOB: _____
City: _____State:_____Zip:_____
Insurance Phone: _____ **Relationship to Patient**: _____

Assignment and Release of Information: I certify that the information given by me is correct. I hereby authorize the release of any information related to my medical care, as requested by government agencies and/or insurance carriers. I hereby assign benefits to the doctor and understand that in the absence of accepted insurance coverage, I/legal guardian are responsible for payment in full for services rendered.
Medicare Patients- I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductible on all services.

X_____ Date_____

Stephen G. Geiger, M.D.

Patient Name: _____ Date: _____
Age: _____ Height: _____ Weight: _____

Family/Referring Physician: _____
Address _____
City: _____ State: _____Zip:_____ Phone: _____

Chief Complaint: _____
Duration of Symptoms
Days: _____ Weeks: _____ Months: _____ Years: _____

Past Medical History

List Medical Problems: _____
List Surgeries & Dates: _____

List Current Medications: _____

List Any Medication Allergies: _____

Does Anyone In Your Family Have Any Of The Following Problems?

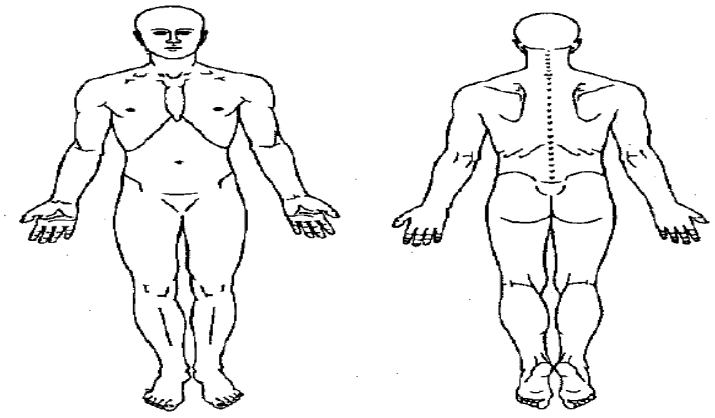
Heart Disease __ Diabetes __ High Blood Pressure __ Nerve Problem __

Do You Have Any Of The Following Symptoms?

Night Pain __ Numbness __ Weakness __ Morning Stiffness __ Joint Pain __

Please mark the area discomfort on the chart below, using the appropriate symbols:

Numbness - - - - - - Pins & Needles o o o o o Burning ^ ^ ^ ^ ^ Aching **x x x x** Stabbing ⊗ ⊗ ⊗ ⊗



Rate Your Pain:
0= No Pain 10= Extreme Pain
1-Right Now: 0 1 2 3 4 5 6 7 8 9 10
2-At Best: 0 1 2 3 4 5 6 7 8 9 10
3-At Worst: 0 1 2 3 4 5 6 7 8 9 10

4-What Makes It Better?
5-What Makes It Worse?

HOSPITAL
FOR
SPECIAL
SURGERY

Stephen G. Geiger, M.D.

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of my physician's Notice of Privacy Practices an have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

_____ _____
Signature of Patient or Patient's Personal Representative Date

_____ _____
Print Name of Patient or Patient's Personal Representative Date

_____ _____
Description of Personal Representative's Authority Date

If you have any question about this notice or would like further information, please contact the office manager.

FOR OFFICE USE ONLY:

If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.

_____

Date_____

HOSPITAL
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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted by the following manner (check all that applies):
___Home Telephone _____
___Cell Phone _____
___Work Telephone _____

Written Communication:
___OK to mail to home address
___OK to mail to work/office
___OK to fax to this number _____ ___Other_____

_____ _____
Patients Signature Date

_____ _____
Print Name Date of Birth

Record of Disclosures of Protected Health Information/ ok to release information to:

1._____ Relationship_____
2._____ Relationship_____
3._____Relationship_____
4._____Relationship_____
5._____Relatioship_____

HOSPITAL
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It is understood and agreed that my purpose for requesting an examination and treatment with **Stephen G. Geiger, M.D.** is for medical purpose only and **not** in connection with pending or proposed litigation. I have no pending or proposed litigation with regards to this medical problem.

Should such litigation arise, it is further understood and agreed that Dr. Stephen G. Geiger will **not** participate in litigation in any way, except to provide a true and accurate copy of any medical records in the possession of this office after receiving authorization from the patient and photocopying fees. It is also understood that this is to be considered a contractual agreement.

Patient
Signature _____ Date _____

Stephen G. Geiger, MD
Physical Medicine and
Rehabilitation
Spine and Sports Medicine
Electromyography (EMG)

Hospital for Special Surgery
Uniondale Affiliated
Physician Office
333 Earle Ovington Blvd.
Suite 106
Uniondale, NY 11553
Tel 516.222.6824
Fax 516.222.7980

Hospital for Special Surgery
Queens Affiliated
Physician Office
176-60 Union Turnpike
Fresh Meadows, NY 11366

HOSPITAL
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ALL PATIENTS:

IF YOU PARTICIPATE IN A HEALTH INSURANCE PLAN, PLEASE READ THE FOLLOWING, SIGN AND DATE:

1. Patient is responsible for obtaining an updated referral from their primary care doctor if the insurance plan requires a referral.

2. If our office does not receive an updated referral at the time of the visit, the patient will be held responsible for payment of the visit.

3. Patient is familiar with the guidelines of their insurance plan and the expiration date of their referral.

4. Any co-payment is payable at the time of the visit. We accept cash or check only.

I HAVE READ THE ABOVE AND UNDERSTAND MY RESPONSIBILITES.

Patient Name _____ Date_____

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Physical Medicine and Rehabilitation
Spine and Sports Medicine
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