

Hospital For Special Surgery Department of Neurology

Patient Name:

_____ (last, first, M.I.)

Date of Birth: _____ Age: _____
(month/day/year)

Social Security #: _____

Sex: _____ (M) _____ (F)

Address: _____

City, State, Zip: _____

Phone numbers:

	Area code/Number	√ if preferred	Best time to call:
Home	()		
Work	()		
Cell	()		

Employment or School Information

___ Full time ___ Part time ___ Student ___ Retired

If retired, date: _____

Employer's Name: _____

Employer's Address: _____

City, State, Zip: _____

Employer's Phone #: _____

Occupation: _____

Marital Status

___ (M) ___ (S) ___ (D) ___ (W) ___ (SEP)

Spouse Name: _____
(Last, First, M.I.)

Spouse Date of Birth: _____
(month/day/year)

Spouse Employment/School Information

___ Full time ___ Part time ___ Student ___ Retired

If retired, date: _____

Employer's Name: _____

Employer's Address: _____

Employer's Phone #: _____

Occupation: _____

Emergency Contact:

Name: _____
(Last, First, M.I.)

Relation: _____

Phone Number(s): _____

Insurance Information:

Guarantor of Insurance:

___ Same as Patient

___ Other (Please fill in the information below)

Name: _____

Relation: _____

Date of Birth: _____

Social Security: _____

Primary Insurance:

Insurance Name: _____

Policy #: _____

Group #: _____

Insurance Address: _____

City, State, Zip: _____

Insurance Phone #: _____

Secondary Insurance:

Insurance Name: _____

Policy #: _____

Group #: _____

Insurance Address: _____

City, State, Zip: _____

Insurance Phone #: _____

HOSPITAL FOR SPECIAL SURGERY

Neurology New Patient Questionnaire

Patient Name _____ M.D. _____ Date _____

Please list all physicians (including referring physician) or other relevant health care professionals (e.g. therapists, chiropractors) involved in your care, and place a check in the box next to those whom you would like to receive a copy of your consultation note.

NAME	ADDRESS	PHONE/FAX	Send note?
Name _____ Specialty: _____	_____	Tel () _____ Fax () _____	<input type="checkbox"/>
Name _____ Specialty: _____	_____	Tel () _____ Fax () _____	<input type="checkbox"/>
Name _____ Specialty: _____	_____	Tel () _____ Fax () _____	<input type="checkbox"/>
Name _____ Specialty: _____	_____	Tel () _____ Fax () _____	<input type="checkbox"/>
Name _____ Specialty: _____	_____	Tel () _____ Fax () _____	<input type="checkbox"/>

What is the reason for your visit today? _____

Is your problem related to a Motor vehicle accident? Work-related injury? (check all that apply)

PAST MEDICAL AND SURGICAL HISTORY (including chemotherapy, radiation, etc.)

<u>Medical problem</u>	<u>Date(s) of diagnosis</u>	<u>Hospitalization or Surgery</u>	<u>Date(s)</u>

If not listed above, please check all that apply:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizure or epilepsy | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> Heart disease/angina | <input type="checkbox"/> Disc problem in spine | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Lyme disease or tick bite |
| <input type="checkbox"/> Asthma/Lung disease | <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Cataracts/cataract surgery |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headache | <input type="checkbox"/> HIV-positive | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Head injury | <input type="checkbox"/> Kidney disease/dialysis | <input type="checkbox"/> Anxiety |

MEDICATIONS (including aspirin, over-the-counter, birth control pills, vitamins, herbal preparations)

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Name</u>	<u>Dose</u>	<u>Frequency</u>

ALLERGIES TO MEDICATIONS

<u>Medication</u>	<u>Type of reaction</u>	<u>Medication</u>	<u>Type of reaction</u>

FAMILY MEDICAL HISTORY

Nationality of Parents:

Could your parents have been related? yes no

Health status and age of Father (if dead; age of death and cause):

Health status and age of Mother (if dead; age of death and cause):

Health status and ages of brothers and sisters:

Health status and ages of children:

Do any members of your immediate or distant family have (circle all that are true): seizures/epilepsy, mental retardation, headaches, weakness, problems walking, wheelchair bound, peripheral neuropathy, muscular dystrophy, ALS, Alzheimer, Parkinson disease?

SOCIAL, OCCUPATIONAL:

Occupation: _____ Spouse/Partner _____

Toxin/chemical exposure _____

Tobacco : No Yes, currently Yes, in past

I smoke(d) about _____ pack/day for _____ years and quit in _____

Alcohol: No Yes, currently Yes, in past

I drink (drank) about _____ per week.

Other drug use: _____

Alcohol or drugs have interfered with my work or home/social life.

Name:

Date of Birth:

Neurological Questionnaire (Review of Systems):

Circle your response as it applies in the question as well as yes/no

Do you have persistent numbness and tingling in the feet? Yes No

Do you have persistent numbness and tingling in the fingers? Yes No

Do you have problems with balance? Yes No

Have you ever fallen? Yes No

Number of falls in past 6 months _____

Do you consistently trip on curbs, cracks in sidewalks, edges of carpets? Yes No

Do you have a tremor in the arms? Worse at rest or during movement? Yes No

Do you have muscle cramps? Yes No

Where _____?

Do you have muscle pain, soreness, and stiffness? Yes No

Has your urine ever been the color of coca cola (almost black)? Yes No

Do your muscles twitch or move under your skin? Yes No

Where _____?

Do you feel overly fatigued without energy? Yes No

Do you have difficulty climbing stairs, arising from chairs, exiting cars? Yes No

Do you have trouble with buttoning buttons, snapping snaps, zipping zippers? Yes No

Has your handwriting deteriorated? Yes No

Do you have trouble lifting your arms over your head (e.g. washing hair)? Yes No

Do you have low back pain? Yes No

Do you have neck pain? Yes No

Do you have neck stiffness? Yes No

Do you have tingling in your arms and legs when you touch your chin to chest? Yes No

Do you have moving pain from your neck/back into your arms/legs? Yes No

When you cough does pain in the arms or legs increase in intensity? Yes No

Do you have problems with bowel and bladder function? Yes No

Do you have problems with sexual function? Yes No

Do you have problems chewing, speaking, swallowing or breathing? Yes No

Do you have facial numbness? Yes No

Do you have problems hearing? Yes No

Do you have problems with dizziness? Yes No

Do you have double vision? Yes No

Do your eyelids ever droop? Yes No

Have you ever gone blind in one or both eyes?	Yes	No
Do you ever have nausea or vomiting with or without headache?	Yes	No
Have you ever had a seizure (convulsion)?	Yes	No
Have you ever blacked out?	Yes	No
Has memory loss ever had an impact on daily activities?	Yes	No
Has your personality changed recently?	Yes	No
Do you find yourself crying or laughing more easily or inappropriately?	Yes	No
Do you have headaches that interfere with daily activities? Take pain relievers?	Yes	No

General Health Questionnaire (General Review of Systems)
(circle all that apply; then explain)

General:		
Have you had a change in appetite or weight.	Yes	No
Do you snore?		
ENT: Do you have sinus or thyroid problems, sore throat, or swollen glands?	Yes	No
Pulmonary: Do you have problems coughing, producing sputum, blood, have Asthma, or use a nebulizer	Yes	No
Cardiac: Do you have hypertension, chest pain, suffered a heart attack, have Swelling in the ankles, or have to sleep on 2 or more pillows to breath?	Yes	No
GI: Do you have nausea, vomiting, abdominal pain, blood in your stools, Constipation or incontinence?	Yes	No
GU: Do you have burning when you urinate, have blood in your urine, or Incontinence?	Yes	No
Endocrine: Have you ever had problems with your thyroid? Have you had problem With hair loss, unexplained weight gain or loss, loss of eyebrows?	Yes	No
Skin: Have you had changes in your ability to bruise, unusual rashes or skin change?	Yes	No
Psychiatric: Have you ever been treated by a psychiatrist for depression or any other problem?	Yes	No

DISCUSSION OF YOUR HEALTH INFORMATION TO OTHER INDIVIDUALS

I authorize Dale Lange, MD to discuss my personal health information with the following individuals:

Signature of patient: _____ **Date:** _____

Notes:

HOSPITAL
FOR
SPECIAL
SURGERY



Department of Neurology
Hospital for Special Surgery
525 East 71st Street
New York, NY 10021
212 606 1050

**RELEASE OF INFORMATION
AND
UNIFORM ASSIGNMENT STATEMENT**

Authorization for Release of Information by Hospital for Special Surgery

I hereby authorize and direct Dr. _____ who is located at the Hospital for Special Surgery, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and/or medical care, all information needed to substantiate payment for such hospitalization and/or medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date

Signature of Patient or Authorized Representative

Assignment to Hospital for Special Surgery

I hereby assign, transfer and set over to Dr. _____ who is located at the Hospital for Special Surgery, sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and/or medical care to cover the cost of the care and treatment rendered to myself or my dependent in said hospital. I understand I am financially responsible for charges not covered by the policy or plan.

Date

Signature of Patient or Authorized Representative



Medicare Questionnaire

Patient name: _____ Date _____ MRI # _____

1. Are you entitled to Medicare based on?

- a. Age b. Disability c. End Stage Renal Disease

Only If you check **c. ESRD** fill out below

Have you received a kidney transplant? If Yes, date of transplant: _____

Have you received maintenance dialysis treatment? If Yes, date dialysis began: _____

Are you within the 30-month coordination period? Yes No

2. Are you currently employed (including self-employment and part-time employment)?

Yes How many people work for your employer? Less than 20 20 or more 100 or more

Name & Address of your employer _____

No If you are not employed, are you retired? If Yes, when did you retire? _____

No Never worked

3. Is your spouse currently working (including self-employment and part-time employment)?

Yes How many people work for their employer? Less than 20 20 or more 100 or more

Name & Address of Employer _____

No (*___ Check if Deceased or No spouse.*) If alive, when did your spouse retire? _____

4. Do you have Group Health Plan coverage based on your own, spouse's or family member's current employment?

Yes (*Fill in information*) Name & address of GHP: _____

No Policy / Group ID#: _____ Subscriber Name _____

Relationship _____

5. Is there any other benefit program (including government programs) that could pay for this service?

Yes (*Check all that apply below*)

No

Black Lung

VA/Tricare

Research Grant

Date benefits began: ____/____/____

If VA, has the Veterans' Affairs authorized and agreed to pay for care at this facility? Yes No

If yes, VA authorization # _____

(Black Lung is primary only for claims related to Black Lung. VA is primary only with VA letter of authorization)

6. Is this service related to an illness or injury that occurred while on your job or in an auto accident? (Or a result of another type of accident for which a person or business has been maybe held responsible?)

Yes (*Fill out details*) Date of accident or injury ____/____/____

No (*No open case*) Insurance company address _____

City: _____ State: _____ Zip: _____

Active Policy **or** Workers' Comp Case # _____

Type of accident: _____

(No Fault is primary only for those claims related to this accident. Worker's Compensation is primary only for claims resulting from work-related injuries/illness.)

Signature _____ Date _____

Hospital For Special Surgery
525 East 71st Street
New York, NY 10021

Records Release Form

Patient Name: _____

(Last, First, M.I.)

Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Name of Provider: _____

I, _____, hereby authorize the release of my medical records, regarding my illness and/or treatment, to the following facilities and/or individuals:

Contact Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Contact Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic evaluations, and radiology reports.

Patient's Signature: _____ **Date:** _____

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ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of my physician's Notice of Privacy Practices and 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 information, 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.

Date

Signature of Patient or Authorized Representative

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