

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? _____

Do you have numbness or tingling? _____

If you do, please write whether it is in your hands, arms, legs, or feet (Circle all that apply) _____

If you do, please state if it is worst in left or right hand or foot, or if equal say equal in both _____

Do you have weakness? _____

If you do, please write which side and which limb (arms or legs or hands or feet) the weakness is in _____

Do you have low back pain? _____

If you do, does it radiate down your legs and which leg? _____

Do you have neck pain? _____

If you do, does it radiate down your arms? _____

Have you tried any of the following medicines before (please circle if any of these apply) and if you had side effects which side effects did you have? Lyrica, Neurontin (Gabapentin), Cymbalta _____

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 |

Continued on reverse side of this page...

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

Medication	Type of reaction	Medication	Type of reaction
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY MEDICAL HISTORY (relevant to your present problem and general conditions that run in the family)

SOCIAL, OCCUPATIONAL:

Occupation: _____ Spouse/Partner _____ Children: yes # of children: _____
 Who do you live with?: _____ I live in a house apartment building ; has elevators yes no
 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.

SYMPTOM CHECK-LIST (REVIEW OF SYSTEMS)

Please place a check mark next to the appropriate box in the following list of symptoms.

	YES	NO		YES	NO
1. GENERAL <input type="checkbox"/> None of the below					
Weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Nightsweats	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problem/easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
2. HEAD AND NECK <input type="checkbox"/> None of the below					
Ringling in the ears (tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds/infections	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Change or loss of taste	<input type="checkbox"/>	<input type="checkbox"/>
Repeated nose bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Headache or facial pain	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Sinus congestion or pain	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in the neck	<input type="checkbox"/>	<input type="checkbox"/>
3. EYES <input type="checkbox"/> None of the below					
Failing or blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
See sparkling lights	<input type="checkbox"/>	<input type="checkbox"/>	Bulging eyes	<input type="checkbox"/>	<input type="checkbox"/>
4. HEART/LUNG <input type="checkbox"/> None of the below					
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Skipping/irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Sit up and breathe easier	<input type="checkbox"/>	<input type="checkbox"/>
Swelling (edema) of feet	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
5. STOMACH/INTESTINES <input type="checkbox"/> None of the below					
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn, abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Any incontinence of stool	<input type="checkbox"/>	<input type="checkbox"/>
Appetite loss	<input type="checkbox"/>	<input type="checkbox"/>	Any black tarry stools	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Any blood from rectum	<input type="checkbox"/>	<input type="checkbox"/>
6. JOINTS AND SPINE <input type="checkbox"/> None of the below					
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain, stiffness or rigidity	<input type="checkbox"/>	<input type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>
7. MUSCLE/NERVE <input type="checkbox"/> None of the below					
Weakness or paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness of hands	<input type="checkbox"/>	<input type="checkbox"/>
Muscle wasting or atrophy	<input type="checkbox"/>	<input type="checkbox"/>	Pain in any limb	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	Tingling in any limb	<input type="checkbox"/>	<input type="checkbox"/>
Muscle jerking	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in any limb	<input type="checkbox"/>	<input type="checkbox"/>
Shaking or tremor	<input type="checkbox"/>	<input type="checkbox"/>	Disturbance in walking or balance	<input type="checkbox"/>	<input type="checkbox"/>
8. NEUROPSYCHOLOGICAL <input type="checkbox"/> None of the below					
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Memory problem	<input type="checkbox"/>	<input type="checkbox"/>
Daytime drowsiness	<input type="checkbox"/>	<input type="checkbox"/>	Speech disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Feeling depressed	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Personality change	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Any alcohol or drug problem	<input type="checkbox"/>	<input type="checkbox"/>
9. GENITOURINARY <input type="checkbox"/> None of the below					
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with erection	<input type="checkbox"/>	<input type="checkbox"/>
Hard to start urinary flow	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with ejaculation	<input type="checkbox"/>	<input type="checkbox"/>
Any leakage/incontinence of urine	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with orgasm	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	Pain on intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	Any other sexual problems	<input type="checkbox"/>	<input type="checkbox"/>
10. FOR WOMEN					
Menstruation began _____			Number of: pregnancies _____ live births _____		
Menopause began _____			Have you Ever had an Abnormal Pap Smear and		
Last menstrual period _____			when was it and what was done _____		
Typical cycle is _____ days in length with			Last Normal Pap smear _____		
menstrual period lasting _____ days.					

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.