

LONG ISLAND NEUROSCIENCE SPECIALISTS

Patient Information Sheet

Name: _____ Date of Birth: ____/____/____
(Last) (First) (Middle Initial)

Sex: ____ Marital Status: ____ Age: ____ Social Security Number: ____ - ____ - ____

Address: _____
STREET ADDRESS OR PO BOX CITY STATE ZIP

Home Number: (____) _____ Work Number: (____) _____ Cell Number: (____) _____

Emergency Number (____) _____ Referring Doctor: _____

Primary Care Physician: _____ Cardiologist: _____

Private Insurance _____ Workers' Compensation _____ No-Fault _____ Medicare/Medicaid _____

Do you currently have an open *Workers' Compensation or No-Fault injury*? YES NO

Insurance carrier name: _____

Does your insurance require a copay? YES NO Amount of copay? \$ _____ (DUE AT TIME OF VISIT)
Does your insurance require a referral? YES NO

MEDICARE PATIENT'S ONLY PLEASE SIGN:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Long Island Neuroscience Specialists for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services.

Patient's Signature: **X** _____ Date: ____/____/____

PATIENT'S USING OUT-OF-NETWORK BENEFITS PLEASE READ AND SIGN:

I am aware that Dr. Sumeer Sathi / Dr. Steven P. Leon / Dr. Meeru Sathi-Welsch do(es) not participate with my insurance. The office policies regarding out-of-network benefits have been explained to me.

Patient's Signature: **X** _____ Date: ____/____/____

PATIENT EMPLOYMENT INFORMATION

Occupation of Patient: _____

Patient Employer: _____ Employer Phone Number: (____) _____

Employer Address: _____
STREET ADDRESS CITY STATE Zip

AUTHORIZATION RELEASE/ASSIGNMENT OF BENEFITS

I authorized the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. Also, I hereby authorize Long Island Neuroscience Specialists to apply for benefits on my behalf for covered services rendered by them. I request that payment from my insurance company be made directly to Long Island Neuroscience Specialists. This authorization may be revoked by either me or my insurance company at any time in writing. I take responsibility for payment of any services rendered by Long Island Neuroscience Specialists.

Patient's Signature: **X** _____ Date: ____/____/____

LONG ISLAND NEUROSCIENCE SPECIALISTS

NO FAULT CLAIMS

Patient Name: _____ Date of Birth: _____

No Fault Carrier: _____
STREET CITY STATE ZIP

Phone Number:(_____)_____ Fax Number:(_____)_____

Address: _____

Contact Name: _____

Date of Accident: ____/____/____

Claim Number: _____

Are you now working?: YES NO Date last worked: ____/____/____

Described how **No Fault** injury occurred: _____

ATTORNEY: _____ (_____) _____
NAME STREET ADDRESS CITY/STATE ZIP PHONE#

PATIENT SIGNATURE TODAY'S DATE

Patient Name: _____ Age: _____ Date of Birth: _____

Name of Physician requesting this consultation: _____

Chief Complaint

Reason for today's visit? _____

Past History: Please list any prior major illnesses and/or injuries:

CURRENT PHARMACY INFORMATION (NAME, ADD, PH#)

Surgeries/Hospitalizations	Year	Complications

Have you ever had problems with anesthesia: _____ YES _____ NO

Current Medication(s) including Aspirin	Dose	Frequency

ALLERGIES/REACTIONS TO MEDICATIONS, ANESTHETIC OR MATERIALS:

Family History

Family history of trouble with anesthesia? _____ YES _____ NO Family history of easy bleeding? _____ YES _____ NO

Family history of Disease/Illness - PLEASE LIST: (checkmark no history if no significant history)

Mother: _____ no history _____

Father: _____ no history _____

Social History

Do you smoke? _____ YES, I've smoked _____ packs of cigarettes per day for _____ years.

_____ YES, I smoke cigars or a pipe

_____ NO, I have never smoked

_____ NO, I quit _____ years ago. At that time I was smoking _____ packs a date for _____ years.

Do you drink alcohol? _____ NO, never (or rarely) _____ NO, but I used to

Beer _____ Liquor _____ Wine _____ YES, _____ daily _____ 1 or more times a week _____ 1 or more time a month

Substance Abuse:

Which of the following, if any, have you used in the past? (Circle all that apply) Indicate ("O")occasional, ("F")frequently, or ("C")continuously

Heroin _____ Barbiturates _____ Cocaine _____ Other _____
Amphetamines _____ Marijuana _____ (specify)

Are you presently using any of the drugs or substances below? (Circle all that apply) Indicate ("O")occasional, ("F")frequently, or ("C")continuously

Heroin _____ Barbiturates _____ Cocaine _____ Other _____
Amphetamines _____ Marijuana _____ (specify)

Patient signature: _____ Date: _____

Review of Systems

Are you currently, or have you had, problem with:

Constitutional **Please Circle**
 Weight gain YES NO
 Weight loss YES NO
 Night Sweats YES NO
 Insomnia YES NO

Eyes
 Double vision YES NO
 Visual loss YES NO

Ear, Nose, Throat and Mouth
 Hearing loss YES NO
 Noise/ringing in ears YES NO
 Nasal congestion YES NO
 Nasal drainage YES NO
 Sore throat YES NO
 Trouble swallowing YES NO
 Hoarseness YES NO

Cardiovascular
 Chest pain or angina YES NO
 Heart trouble YES NO
 Rheumatic fever YES NO
 Heart murmur YES NO
 High blood pressure YES NO

Respiratory **Circle One**
 Asthma YES NO
 Cough up blood YES NO
 TB YES NO
 Pneumonia YES NO
 Trouble breathing at night YES NO
 Snoring YES NO

Gastrointestinal
 Indigestion or heartburn YES NO
 Ulcer YES NO
 Hepatitis YES NO
 Jaundice YES NO
 Blood in stool YES NO
 Black, tarry stools YES NO

Genitourinary **Please Circle**
 Bladder trouble YES NO
 Prostate disease YES NO
 Kidney disease YES NO

Musculoskeletal
 Arthritis YES NO

Neurological
 Numbness YES NO
 Weakness YES NO
 Stroke YES NO
 Headache YES NO

Psychiatric
 Depression YES NO

Endocrine
 Diabetes YES NO
 Thyroid disease YES NO

Hematologic
 Bleeding disorder YES NO
 Easy bleeding YES NO

Allergic/Immunologic
 Sneezing YES NO
 Itchy eyes/nose YES NO
 Itchy throat YES NO
 Skin rash YES NO
 HIV YES NO

Are you working at this time? YES NO

If Yes: Part-time Full-time
 Date last worked: _____

If not working, reason: _____

Do you have a sedentary job? YES NO

Are you working without restrictions? YES NO

List restrictions: _____

The above information is accurate to the best of my knowledge.

 Patient Signature Date

I have reviewed the above information with the patient.

 Physician Signature Date

 Physician Signature Date

 Physician Signature Date

LONG ISLAND NEUROSCIENCE SPECIALISTS, LLP

Patient Name: _____

Primary Language _____ (please fill in) _____ Patient declined/unknown

Race: ___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ Native Hawaiian or other Pacific Islander ___ White ___ Other ___ Patient declined/unknown

Ethnicity: ___ Spanish/Hispanic origin ___ Not of Spanish/Hispanic Origin ___ Patient declined/unknown

PRIVACY INFORMATION PREFERENCES

Can we call you and leave a message on your Home Phone? _____ Yes _____ No
Can we call you and leave a voicemail on your Cell Phone? _____ Yes _____ No
Can we call you and leave a voicemail on your Work Phone? _____ Yes _____ No
Who can we leave messages with? _____ Wife _____ Husband _____ Daughter _____ Son
_____ Other _____
Can we send you a reminder via mail? _____ Yes _____ No
Can we send you a reminder via email? _____ Yes _____ No (email) _____

**Acknowledgment of Receipt of
LONG ISLAND NEUROSCIENCE SPECIALISTS
Notice of Patient Privacy**

By my signature below, I hereby acknowledge receipt of this Notice of Privacy Practices, and I acknowledge that the Practice will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting health care operations.

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations LONG ISLAND NEUROSCIENCE SPECIALISTS may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

Please check the appropriate boxes (if applicable)

If I am unavailable, I expressly **DO NOT** permit LONG ISLAND NEUROSCIENCE SPECIALISTS to disclose my protected health information—for the purposes of appointment/test/procedure reminders and follow-up—to the following individuals:

DO NOT release my medical records to the following:

_____ (relationship to me)
_____ (relationship to me)
_____ (relationship to me)

If the information to be disclosed contains information concerning drug or alcohol treatment, or psychiatric care, please check one or both of the following if you do not wish to have this information released:

- Do not release medical records containing information concerning drug abuse or alcohol treatment/abuse.**
- Do not release medical records concerning psychiatric treatment.**

Signature of Patient or of
Personal Representative, or parent/guardian

Date: _____

Print Name



**Long Island
Neuroscience
Specialists**

Affiliated with Department of Neurological Surgery
Weill Cornell Medical College



Weill Cornell Medical College

Neurological and Spine Surgeon

Sumeer Sathi, M.D., F.A.C.S., Clinical Assistant Professor

Steven P. Leon, M.D., F.A.C.S., Clinical Assistant Professor

Pain Management

Meeru Sathi-Welsch, M.D., Clinical Assistant Professor

I _____, allow the release of my medical records to be sent to:

Long Island Neuroscience Specialists at 100 Hospital Road, Suite 216, East Patchogue, NY 11772.

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____

Zip Code: _____

Patient Signature: _____