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

PRIVATE INSURANCE INFORMATION

Patient Name: _____ Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___

Primary Insurance

Carrier: _____

Insurance Company Address: _____
Street Address of PO Box City State Zip

Insurance Company Phone Number:
_____

Policy Number: _____ Group:_____

Effective Date: _____/_____/_____

Name of Insured: _____

Insured Date of Birth:_____/_____/_____ Insured relationship to patient:
_____

Insured Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Secondary Insurance

Carrier: _____

Insurance Company Address: _____
Street Address of PO Box City State Zip

Insurance Company Phone Number:
_____

Policy Number: _____ Group:_____

Effective Date: _____/_____/_____

Name of Insured: _____

Insured Date of Birth: _____/_____/_____ Insured relationship to patient:
_____

Insured Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Patient Health History Form page 1

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/Illiness - 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 <u>past?</u> (Circle all that apply) Indicate ("O")occasional, ("F")frequently, or ("C")continuously

Heroin_____ Barbiturates_____ Cocaine _____ Other _____

Amphetamines _____ Marijuana _____ (specify)

Are you <u>presently</u> 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

I have reviewed the above information with the patient.

_____ _____

Physician Signature Date

_____ _____

Physician Signature Date

_____ _____

Physician Signature Date

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

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.**

_____ Date: _____
Signature of Patient or of
Personal Representative, or parent/guardian

_____
Print Name

Long Island Neuroscience Specialists

Affiliated with Department of Neurological Surgery
Weill Cornell Medical College

Weill Cornell Medical College

Neurological and Spine Surger
Sumeer Sathi, M.D., F.A.C.S., Clinical Assistant Professc
Steven P, Leon, M.D., F.A.C.S., Clinical Assistar
Pain Managemer
Meeru Sathi-Welsch, M.D., Clinical Assistant Professc

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: _____