

# 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 Number: \_\_\_\_\_

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
TODAYS DATE



**Neurological and Spine Surgery**  
*Sumeer Sathi, M.D., F.A.C.S., Clinical Assistant Professor*  
*Steven P. Leon, M.D., F.A.C.S., Clinical Assistant*  
**Pain Management**  
*Meeru Sathi-Welsch, M.D., Clinical Assistant Professor*

Affiliated with Department of Neurological Surgery  
 Weill Cornell Medical College



**Initial Pain Assessment**

**Name:** \_\_\_\_\_

***By answering the following questions, you will help your physician better understand and treat your pain.***

When and how did your pain problem start?: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What is the cause of your pain (i.e., diagnosis)?: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What doctors have you seen? When did you see them? What treatments did they provide?

<u>Doctor's Name</u>	<u>Month/Year Seen</u>	<u>Treatment</u>
	(Physical exam/ Medication)	
_____	_____	_____
_____	_____	_____
_____	_____	_____

What tests and/or diagnostic testing were ordered? (For example, MRI's, X-Rays and CT Scans)

<u>Diagnostic Study</u>	<u>Month/Year</u>	<u>Results</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: \_\_\_\_\_

### **General Health Review**

**Medical History** (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, etc)

\_\_\_\_\_  
\_\_\_\_\_

**Surgical History** (such as appendectomy, laminectomy, etc)

\_\_\_\_\_  
\_\_\_\_\_

**Psychiatric History**

-Are you presently or in the past being treated for any of the below conditions?

- |  |   |
|--|---|
| <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> Depression       |
| <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Bipolar disorder |
| <input type="checkbox"/> Schizophrenia                 | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Attention Deficit Disorder    |   |

Do you see a counselor: \_\_\_ YES \_\_\_ NO, If yes what is their name and contact information?

\_\_\_\_\_

**Current Medications** (include vitamins and birth control pills, if applicable)

\_\_\_\_\_  
\_\_\_\_\_

**Allergies** (include medication and food allergies) **IF NONE, PLEASE INDICATE**

\_\_\_\_\_  
\_\_\_\_\_

**Intolerances**(include side effects from previous meds, such as gastritis, nausea, constipation, etc)

\_\_\_\_\_  
\_\_\_\_\_

**Family History**

Family History of trouble with anesthesia? \_\_\_ YES \_\_\_ NO or Easy bleeding? \_\_\_ YES \_\_\_ NO

Family History of substance abuse? (alcohol, illegal drugs, prescription drugs) \_\_\_\_\_

**Family History of disease/illness - PLEASE LIST:** (checkmark no history if no significant history)

Mother: \_\_\_\_\_ no history \_\_\_\_\_

Father: \_\_\_\_\_ no history \_\_\_\_\_

**Do you have any of the following? (Circle all that apply)**

- |                 |                     |                       |
|-----------------|---------------------|-----------------------|
| HEADACHES       | SHORTNESS OF BREATH | DIARRHEA              |
| STOMACH PAIN    | HEARING PROBLEMS    | SWOLLEN JOINTS        |
| CHEST PAIN      | VOMITING            | CHRONIC FATIGUE       |
| VISION PROBLEMS | URINARY PROBLEMS    | DIFFICULTY SWALLOWING |
| NAUSEA          | DIZZINESS           |                       |
| CONSTIPATION    | RASHES              |                       |

Name: \_\_\_\_\_

**Domestic Situation**

With whom do you live? \_\_\_\_\_

Are there any substance abuse issues in the household? YES \_\_\_\_ NO \_\_\_\_

If yes, please explain \_\_\_\_\_

Are you able to care of yourself? YES \_\_\_\_ NO \_\_\_\_

If not, please enter name of care giver: \_\_\_\_\_

**Work History**

JOB	YEARS WORKED	WHY DID YOU LEAVE?
_____	_____	_____
_____	_____	_____

**Legal Matters**

Are you presently involved in a lawsuit? YES \_\_\_\_ NO \_\_\_\_

If yes, please explain \_\_\_\_\_

**Substance Abuse**

Which of the following drugs or substances, *if any*, have you ever used? (Check all that apply.)

	NEVER	PAST	CURRENT (please indicate if it is regularly, sporadically or addiction)
Barbiturates	_____	_____	_____
Heroin	_____	_____	_____
Cocaine	_____	_____	_____
Marijuana	_____	_____	_____
Amphetamines	_____	_____	_____
Suboxone	_____	_____	_____
Methadone	_____	_____	_____
Other _____	_____	_____	_____

**Alcohol:**

- Do you occasionally \_\_\_\_, rarely \_\_\_\_, or never \_\_\_\_ consume alcohol?
- If so, do you drink \_\_ Beer, \_\_ Liquor, or \_\_ Wine?
- Do you currently smoke cigarettes or use tobacco in any form? Yes \_\_\_\_ No \_\_\_\_
- If yes, how many packs/cigarettes do you smoke per day? \_\_\_\_
- If not, did you ever smoke cigarettes or use tobacco in any form in the past? Yes \_\_\_\_ No \_\_\_\_
- If so, how many packs/cigarettes did you smoke a day? \_\_\_\_ For how many years? \_\_\_\_

Name: \_\_\_\_\_

List the body sites where you experience pain and circle the words that best describe the pain at that site. Also, indicate the intensity of the pain and those things that make your pain better or worse.

Body Site: \_\_\_\_\_

**Circle the words that describe your pain:**

Aching	Sharp	Penetrating
Shooting	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Exhausting	Unbearable
Intermittent	Continuous	

Circle the Number that best describes your pain at its **worst during the past month**:

**0**    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**  
(No pain) (Worst pain imaginable)

Circle the Number that best describes your pain at its least **during the past month**:

**0**    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**  
(No pain) (Worst pain imaginable)

Circle the Number that best describes your pain **on average during the past month**:

**0**    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**  
(No pain) (Worst pain imaginable)

Circle the Number that best describes your pain **right now**:

**0**    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**  
(No pain) (Worst pain imaginable)

What makes your pain feel **better**: (for example: heat, rest, medication)?

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What makes your pain feel **worse**: (for example: walking, standing, lifting)?

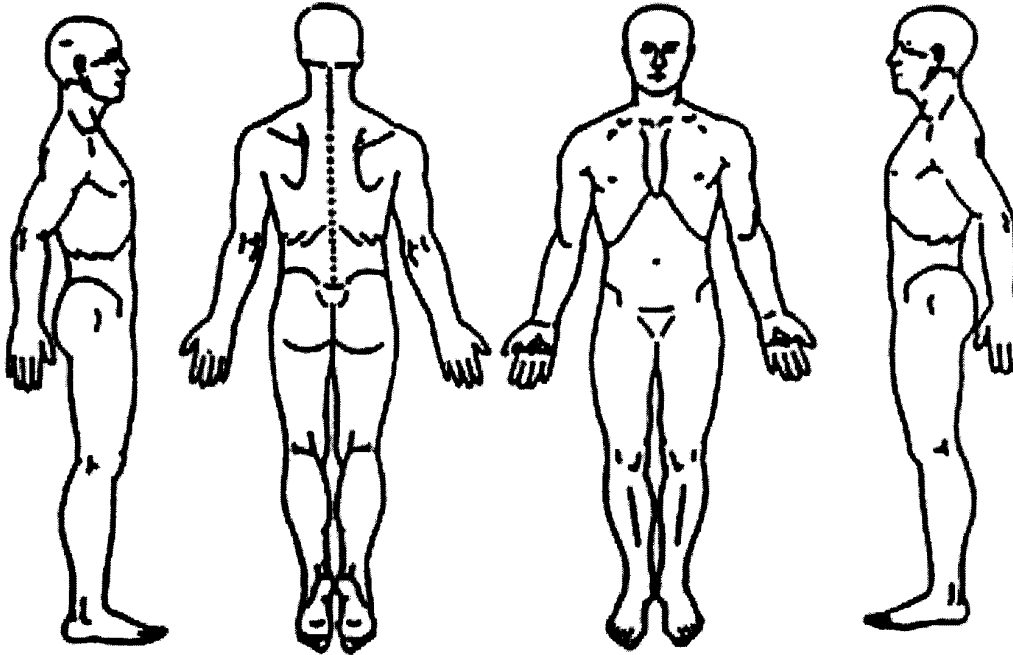
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Name: \_\_\_\_\_

On the diagram below, shade the area(s) where you feel pain. "X" the areas that hurt the most.



What pain treatments or medications are you receiving now or have received in the past? (For example, pain medications, Physical Therapy, Acupuncture, TENS, etc.) Circle the number next to the treatment to signify the amount of pain relief that treatment is providing or has provided.

Treatment or Medication	0	1	2	3	4	5	6	7	8	9	10	Check if receiving now
_____												<input type="checkbox"/>
_____												<input type="checkbox"/>
_____												<input type="checkbox"/>
_____												<input type="checkbox"/>
_____												<input type="checkbox"/>
_____												<input type="checkbox"/>

Name: \_\_\_\_\_

Circle the number below that best describe how pain has interfered with your daily functioning. (0=does not interfere, 10=completely interferes)

**General Activity**

0 1 2 3 4 5 6 7 8 9 10

**Mood**

0 1 2 3 4 5 6 7 8 9 10

**Walking Ability**

0 1 2 3 4 5 6 7 8 9 10

**Normal Work Routine**

0 1 2 3 4 5 6 7 8 9 10

**Relations with Other People**

0 1 2 3 4 5 6 7 8 9 10

**Sleep**

0 1 2 3 4 5 6 7 8 9 10

**Enjoyment of Life**

0 1 2 3 4 5 6 7 8 9 10

**Ability to Concentrate**

0 1 2 3 4 5 6 7 8 9 10

**Appetite**

0 1 2 3 4 5 6 7 8 9 10

**What level of pain do you think you could function with on a daily basis?**

0 1 2 3 4 5 6 7 8 9 10



# Patient Health History Form

## 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
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### Neurological

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

### Psychiatric

Depression	YES	NO
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### 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)

**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**

**Neurological and Spine Surgery**  
*Sumeer Sathi, M.D., F.A.C.S., Clinical Assistant Professor*  
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Affiliated with Department of Neurological Surgery  
Weill Cornell Medical College



Weill Cornell Medical College

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:** \_\_\_\_\_