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. I take responsibility for payment of any services rendered by Long Island Neuroscience Specialists.

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

If patient cannot sign, signature witnessed by office staff: ______________________ **Date:** _____/_____/_____

LONG ISLAND NEUROSCIENCE SPECIALISTS

PRIVATE INSURANCE INFORMATION

Patient Name: ______________________________ **Date of Birth**: ____/____/_____

Primary Insurance

Carrier: ____

Insurance Company Address: ____
Street Address or 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

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 past? (Circle all that apply) Indicate ("O")occasional, ("F")frequently, or ("C")continuously

Heroin________ Barbiturates_________ Cocaine ___________ Other _______________ (specify)

Amphetamines ________ Marijuana __________

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 _______________ (specify)

Amphetamines ________ Marijuana __________

Patient signature: ______________________________ Date: ____________________

If patient cannot sign, signature witnessed by office staff: ____________________ Date: __________

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 __________

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** __________

If patient cannot sign, signature witnessed by office staff:

Signature: ____________________ **Date:** __________

LONG ISLAND NEUROSCIENCE SPECIALISTS, LLP

Patient Name: ____
Primary Language ____________________
Race: ___ American Indian or Alaska Native ____ Asian ____ Black or African American ____ Native Hawaiian or other Pacific Islander ____ White ___ Other ____ declined/unknown
Ethnicity: ____Spanish/Hispanic origin ____Not of Spanish/Hispanic Origin ____ 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? ____
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.**

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

____
Print Name

If patient cannot sign, signature witnessed by office staff: ______________________ **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

Weill Cornell Medical College

I ____, allow the release of my medical records to be sent to: **Long Island Neuroscience Specialists at 285 Sills Road, Building 5-6, Suite E, East Patchogue, NY 11772.**

Date of Birth: ____________________________________

Address: ____

City/Zip: ____

Patient Signature: _________________________________ **Date:** ____________

If patient cannot sign, signature witnessed by office staff:

Signature: ____________________________ **Date:** ______________