

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: _____ - _____ - _____



**Long Island
Neuroscience
Specialists**

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

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**

Intolerance(include side effects from previous medications, 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:**

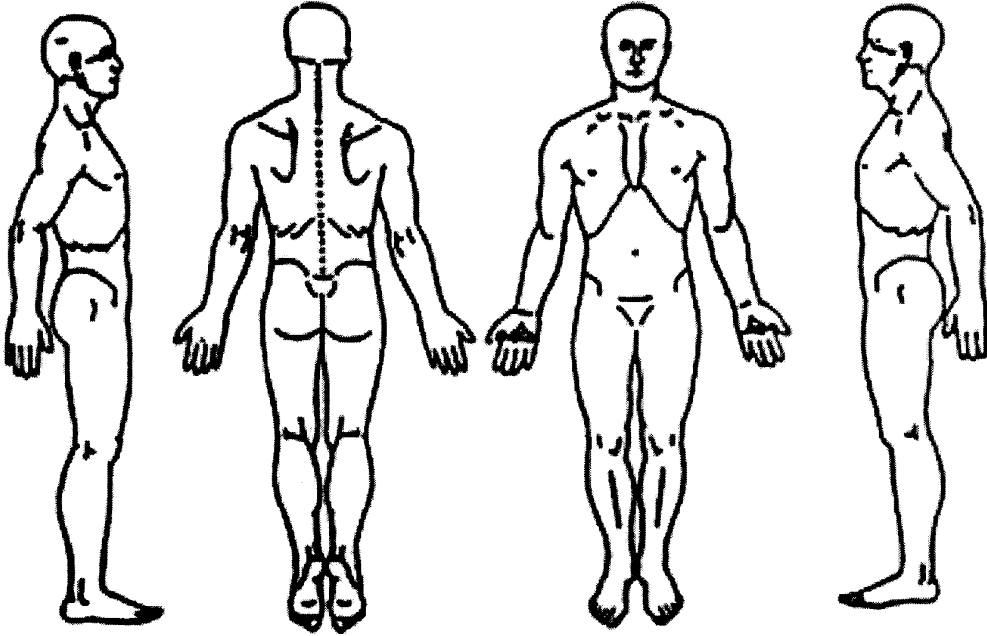
0 1 2 3 4 5 6 7 8 9 10
(No pain) (Worst pain imaginable)

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

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

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

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

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.**

Signature of Patient, Personal Representative or parent/guardian

Date: _____

Print Name

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



Affiliated with Department of Neurological Surgery
Weill Cornell Medical College

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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:** _____