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

WORKERS' COMPENSATION CLAIMS

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

Workers' Compensation Carrier: ______________________________

Phone Number: (______)______________ Fax Number:(______)______________

Address: ______________________________

Contact Name: ______________________

Date of Accident: __________/__________/__________

Workers' Compensation Board Number: ______________________________

Carrier Case Number: ______________________________

Employer *(at time of injury)*:

Name: ______________________________

Address: ____________________ City ______________State________ ZIP________

Job Title: ______________________________

On ***date of injury*** what were your usual work activities?: ______________________________

Have you missed work due to Injury? YES or NO ***If no,*** date last worked:_______/_______/________

Are you currently working?: YES NO ***If yes,*** did you return to: ____usual work activities ___limited work activities

Describe how ***Workers' Compensation*** injury occurred:______________________________

____

____

____

______________________________ PATIENT SIGNATURE

________/__________/__________ TODAYS DATE

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

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?

Doctor's Name	Month/Year Seen	Treatment (Physical exam/ Medication)

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

Diagnostic Study	Month/Year	Results

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?

- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia
- ☐ Attention Deficit Disorder
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Other

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
STOMACH PAIN
CHEST PAIN
VISION PROBLEMS
NAUSEA
CONSTIPATION
SHORTNESS OF BREATH
HEARING PROBLEMS
VOMITING
URINARY PROBLEMS
DIZZINESS
RASHES
DIARRHEA
SWOLLEN JOINTS
CHRONIC FATIGUE
Difficulty Swallowing

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

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

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

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

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

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

0 (No pain) **1 2 3 4 5 6 7 8 9 10** (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												Check if receiving now
______________	0	1	2	3	4	5	6	7	8	9	10	☐
______________	0	1	2	3	4	5	6	7	8	9	10	☐
______________	0	1	2	3	4	5	6	7	8	9	10	☐
______________	0	1	2	3	4	5	6	7	8	9	10	☐
______________	0	1	2	3	4	5	6	7	8	9	10	☐
______________	0	1	2	3	4	5	6	7	8	9	10	☐

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
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
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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:** ______________