Stephen G. Geiger, M.D. **REVISIT UPDATE FORM**
Physical Medicine and Rehabilitation
Phone: 516-222-6824/ Fax: 516-222-7980

New Patient Registration and Demographics

Date: _____

Name: _____ Home Phone: _____
Work Phone: _____
Address: _____ Cell Phone: _____

City: _____ State: ___ Zip: _____ Date of Birth: _____

Employer: _____ Soc. Sec. #: _____

Address: _____ Martial Status: _____Sex: _____
City: _____ State: ___ Zip: _____ Ethnicity: _____Race: _____
Language: _____

Pharmacy Name/Address: _____
_____ Pharmacy Number: _____
City: _____ State: ___ Zip: _____ **Drug Allergies**: _____

Insurance Information

Primary
Insurance Name _____ **Policy Holder**:_____

ID #: _____ Group #:_____

Address: _____ Policy Holder DOB:_____
City: _____ State: ___ Zip: _____
Insurance Phone:_____ **Relationship to Patient**: _____

Secondary
Insurance Name: _____ **Policy Holder**: _____

ID #: _____ Group #:_____

Address: _____ Policy Holder DOB: _____
City: _____ State: ___ Zip: _____
Insurance Phone: _____ **Relationship to Patient**: _____

Assignment and Release of Information: I certify that the information given by me is correct. I hereby authorize the release of any information related to my medical care, as requested by government agencies and/or insurance carriers. I hereby assign benefits to the doctor and understand that in the absence of accepted insurance coverage, I/legal guardian are responsible for payment in full for services rendered.
Medicare Patients: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductible on all services.

X _____ **Date** _____

Stephen G. Geiger, M.D. **Follow Up Form**

Patient Name: _____ Date: _____

Please check one: Follow up _____ New Injury _____

Have there been any changes in your health since your last office visit?
Check one: No_____ stop here.
Yes_____ continue filling out the form.

Chief Complaint:_____
Duration of Symptoms
Days: _____ Weeks: _____ Months: _____ Years: _____

Past Medical History

List Medical Problems: _____

_____

List Surgeries & Dates: _____

_____

List Current Medications: _____

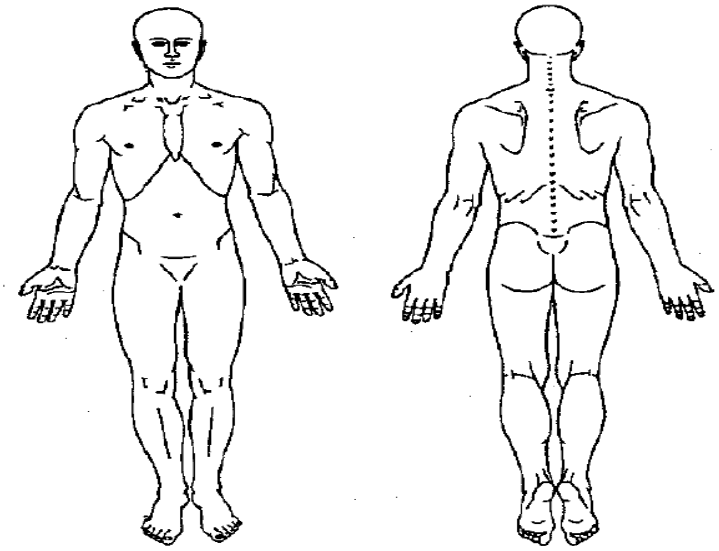
_____

List Any Medication Allergies: _____

_____

Please mark the area discomfort on the chart below, using the appropriate symbols:

Numbness - - - - - -
Pins & Needles o o o o o
Burning ^ ^ ^ ^ ^
Aching x x x x
Stabbing ⊗ ⊗ ⊗ ⊗



Rate Your Pain:
0= No Pain 10= Extreme Pain

1-Right Now: 0 1 2 3 4 5 6 7 8 9 10
2-At Best: 0 1 2 3 4 5 6 7 8 9 10
3-At Worst: 0 1 2 3 4 5 6 7 8 9 10

4-What Makes It Better?

_____

_____

5-What Makes It Worse?

_____

_____

HOSPITAL FOR SPECIAL SURGERY

Stephen G. Geiger, M.D.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contact by the following manner (check all that applies):

_____ Home Telephone_____
_____ Cell Phone_____
_____ Work Telephone _____

Written Communication:

_____ OK to mail to home address
_____ OK to mail to work/office
_____ OK to fax to this number _____ _____ Other _____

_____ _____
Patient Signature Date

_____ _____
Print Name Date of Birth

Records of Disclosures of Protected Health Information/ ok to release information to:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____
4. _____ Relationship _____
5. _____ Relationship _____