

Hospital For Special Surgery Department of Neurology

Patient Name:

_____ (last, first, M.I.)

Date of Birth: _____ Age: _____
(month/day/year)

Social Security #: _____

Sex: _____ (M) _____ (F)

Address: _____

City, State, Zip: _____

Phone numbers:

	Area code/Number	√ if preferred	Best time to call:
Home	()		
Work	()		
Cell	()		

Employment or School Information

___ Full time ___ Part time ___ Student ___ Retired

If retired, date: _____

Employer's Name: _____

Employer's Address: _____

City, State, Zip: _____

Employer's Phone #: _____

Occupation: _____

Marital Status

___ (M) ___ (S) ___ (D) ___ (W) ___ (SEP)

Spouse Name: _____
(Last, First, M.I.)

Spouse Date of Birth: _____
(month/day/year)

Spouse Employment/School Information

___ Full time ___ Part time ___ Student ___ Retired

If retired, date: _____

Employer's Name: _____

Employer's Address: _____

Employer's Phone #: _____

Occupation: _____

Emergency Contact:

Name: _____
(Last, First, M.I.)

Relation: _____

Phone Number(s): _____

Insurance Information:

Guarantor of Insurance:

_____ Same as Patient

_____ Other (Please fill in the information below)

Name: _____

Relation: _____

Date of Birth: _____

Social Security: _____

Primary Insurance:

Insurance Name: _____

Policy #: _____

Group #: _____

Insurance Address: _____

City, State, Zip: _____

Insurance Phone #: _____

Secondary Insurance:

Insurance Name: _____

Policy #: _____

Group #: _____

Insurance Address: _____

City, State, Zip: _____

Insurance Phone #: _____

HOSPITAL FOR SPECIAL SURGERY

Neurology New Patient Questionnaire

Patient Name _____ M.D. _____ Date _____

Please list all physicians (including referring physician) or other relevant health care professionals (e.g. therapists, chiropractors) involved in your care, and place a check in the box next to those whom you would like to receive a copy of your consultation note.

NAME	ADDRESS	PHONE/FAX	Send note?
Name _____ Specialty: _____	_____	Tel () _____ Fax () _____	<input type="checkbox"/>
Name _____ Specialty: _____	_____	Tel () _____ Fax () _____	<input type="checkbox"/>
Name _____ Specialty: _____	_____	Tel () _____ Fax () _____	<input type="checkbox"/>
Name _____ Specialty: _____	_____	Tel () _____ Fax () _____	<input type="checkbox"/>
Name _____ Specialty: _____	_____	Tel () _____ Fax () _____	<input type="checkbox"/>

What is the reason for your visit today? _____

Is your problem related to a Motor vehicle accident? Work-related injury? (check all that apply)

PAST MEDICAL AND SURGICAL HISTORY (including chemotherapy, radiation, etc.)

<u>Medical problem</u>	<u>Date(s) of diagnosis</u>	<u>Hospitalization or Surgery</u>	<u>Date(s)</u>

If not listed above, please check all that apply:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizure or epilepsy | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> Heart disease/angina | <input type="checkbox"/> Disc problem in spine | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Lyme disease or tick bite |
| <input type="checkbox"/> Asthma/Lung disease | <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Cataracts/cataract surgery |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headache | <input type="checkbox"/> HIV-positive | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Head injury | <input type="checkbox"/> Kidney disease/dialysis | <input type="checkbox"/> Anxiety |

MEDICATIONS (including aspirin, over-the-counter, birth control pills, vitamins, herbal preparations)

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Name</u>	<u>Dose</u>	<u>Frequency</u>

ALLERGIES TO MEDICATIONS

<u>Medication</u>	<u>Type of reaction</u>

FAMILY MEDICAL HISTORY (relevant to your present problem and general conditions that run in the family)

Continued on reverse side of this page... Questionnaire reviewed by physician _____

HOSPITAL
FOR
SPECIAL
SURGERY



Department of Neurology
Hospital for Special Surgery
525 East 71st Street
New York, NY 10021
212 606 1050

**RELEASE OF INFORMATION
AND
UNIFORM ASSIGNMENT STATEMENT**

Authorization for Release of Information by Hospital for Special Surgery

I hereby authorize and direct Dr. _____ who is located at the Hospital for Special Surgery, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and/or medical care, all information needed to substantiate payment for such hospitalization and/or medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date

Signature of Patient or Authorized Representative

Assignment to Hospital for Special Surgery

I hereby assign, transfer and set over to Dr. _____ who is located at the Hospital for Special Surgery, sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and/or medical care to cover the cost of the care and treatment rendered to myself or my dependent in said hospital. I understand I am financially responsible for charges not covered by the policy or plan.

Date

Signature of Patient or Authorized Representative

Hospital For Special Surgery
525 East 71st Street
New York, NY 10021

Records Release Form

Patient Name: _____

(Last, First, M.I.)

Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Name of Provider: _____

I, _____, hereby authorize the release of my medical records, regarding my illness and/or treatment, to the following facilities and/or individuals:

Contact Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Contact Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic evaluations, and radiology reports.

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



Medicare Questionnaire

Patient name: _____ Date _____ MRI # _____

1. Are you entitled to Medicare based on?

- a. Age b. Disability c. End Stage Renal Disease

Only If you check **c. ESRD** fill out below

Have you received a kidney transplant? If Yes, date of transplant: _____

Have you received maintenance dialysis treatment? If Yes, date dialysis began: _____

Are you within the 30-month coordination period? Yes No

2. Are you currently employed (including self-employment and part-time employment)?

Yes How many people work for your employer? Less than 20 20 or more 100 or more

Name & Address of your employer _____

No If you are not employed, are you retired? If Yes, when did you retire? _____

No Never worked

3. Is your spouse currently working (including self-employment and part-time employment)?

Yes How many people work for their employer? Less than 20 20 or more 100 or more

Name & Address of Employer _____

No (*___ Check if Deceased or No spouse.*) If alive, when did your spouse retire? _____

4. Do you have Group Health Plan coverage based on your own, spouse's or family member's current employment?

Yes (*Fill in information*) Name & address of GHP: _____

No Policy / Group ID#: _____ Subscriber Name _____

Relationship _____

5. Is there any other benefit program (including government programs) that could pay for this service?

Yes (*Check all that apply below*)

No

Black Lung

VA/Tricare

Research Grant

Date benefits began: ____/____/____

If VA, has the Veterans' Affairs authorized and agreed to pay for care at this facility? Yes No

If yes, VA authorization # _____

(Black Lung is primary only for claims related to Black Lung. VA is primary only with VA letter of authorization)

6. Is this service related to an illness or injury that occurred while on your job or in an auto accident? (Or a result of another type of accident for which a person or business has been maybe held responsible?)

Yes (*Fill out details*) Date of accident or injury ____/____/____

No (*No open case*) Insurance company address _____

City: _____ State: _____ Zip: _____

Active Policy **or** Workers' Comp Case # _____

Type of accident: _____

(No Fault is primary only for those claims related to this accident. Worker's Compensation is primary only for claims resulting from work-related injuries/illness.)

Signature _____ Date _____



ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of my physician's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS – related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians and staff.

Date

Signature of Patient or Authorized Representative

If you have any questions about this notice or would like further information, please contact the office manager.