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, Sate, Zip: _____

Insurance Phone #: _____

Secondary Insurance:

Insurance Name: _____

Policy #: _____

Group #: _____

Insurance Address: _____

City, Sate, 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** ( )	
Name_____ **Specialty:**	_____	**Tel** ( ) **Fax** ( )	
Name_____ **Specialty:**	_____	**Tel** ( ) **Fax** ( )	
Name_____ **Specialty:**	_____	**Tel** ( ) **Fax** ( )	
Name_____ **Specialty:**	_____	**Tel** ( ) **Fax** ( )	

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.)

Medical problem	Date(s) of diagnosis	Hospitalization or Surgery	Date(s)

If not listed above, please check all that apply:

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

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

Name	*Dose*	*Frequency*	*Name*	*Dose*	*Frequency*

ALLERGIES TO MEDICATIONS

Medication	Type of reaction	Medication	Type of reaction

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_____

SOCIAL, OCCUPATIONAL:

Occupation: _____ Spouse/Partner_____ Children: ☐ yes # of children:_____
Who do you live with?:_____ I live in a ☐ house ☐ apartment building ; has elevators ☐ yes ☐ no
Toxin/chemical exposure_____
Tobacco : ☐ No ☐ Yes, currently ☐ Yes, in past I smoke(d) about _____ pack/day for _____ years and quit in _____
Alcohol: ☐ No ☐ Yes, currently ☐ Yes, in past I drink (drank) about _____ per week.
Other drug use: _____ ☐ Alcohol or drugs have interfered with my work or home/social life.

SYMPTOM CHECK-LIST (REVIEW OF SYSTEMS)

Please place a check mark next to the appropriate box in the following list of symptoms.

	YES	NO		YES	NO
1. GENERAL	☐ None of the below				
Weight loss or gain	☐	☐	Itching	☐	☐
Fever	☐	☐	Rash	☐	☐
Nightsweats	☐	☐	Bleeding problem/easy bruising	☐	☐
2. HEAD AND NECK	☐ None of the below				
Ringing in the ears (tinnitus)	☐	☐	Frequent colds/infections	☐	☐
Hearing loss	☐	☐	Change or loss of taste	☐	☐
Repeated nose bleeding	☐	☐	Difficulty in swallowing	☐	☐
Headache or facial pain	☐	☐	Prolonged hoarseness	☐	☐
Sinus congestion or pain	☐	☐	Swelling in the neck	☐	☐
3. EYES	☐ None of the below				
Failing or blurry vision	☐	☐	Eye pain	☐	☐
Double vision	☐	☐	Dry eyes	☐	☐
See sparkling lights	☐	☐	Bulging eyes	☐	☐
4. HEART/LUNG	☐ None of the below				
Chest pain	☐	☐	Shortness of breath	☐	☐
Skipping/irregular heart beat	☐	☐	Sit up and breathe easier	☐	☐
Swelling (edema) of feet	☐	☐	Chronic cough	☐	☐
5. STOMACH/INTESTINES	☐ None of the below				
Nausea or vomiting	☐	☐	Diarrhea	☐	☐
Heartburn, abdominal pain	☐	☐	Any incontinence of stool	☐	☐
Appetite loss	☐	☐	Any black tarry stools	☐	☐
Constipation	☐	☐	Any blood from rectum	☐	☐
6. JOINTS AND SPINE	☐ None of the below				
Joint pain	☐	☐	Neck pain, stiffness or rigidity	☐	☐
Joint swelling	☐	☐	Low back pain	☐	☐
7. MUSCLE/NERVE	☐ None of the below				
Weakness or paralysis	☐	☐	Clumsiness of hands	☐	☐
Muscle wasting or atrophy	☐	☐	Pain in any limb	☐	☐
Muscle spasm	☐	☐	Tingling in any limb	☐	☐
Muscle jerking	☐	☐	Numbness in any limb	☐	☐
Shaking or tremor	☐	☐	Disturbance in walking or balance	☐	☐
8. NEUROPSYCHOLOGICAL	☐ None of the below				
Fatigue	☐	☐	Memory problem	☐	☐
Daytime drowsiness	☐	☐	Speech disturbance	☐	☐
Insomnia	☐	☐	Feeling depressed	☐	☐
Dizziness	☐	☐	Personality change	☐	☐
Fainting	☐	☐	Eating disorder	☐	☐
Loss of consciousness	☐	☐	Any alcohol or drug problem	☐	☐
9. GENITOURINARY	☐ None of the below				
Frequent urination	☐	☐	Difficulty with erection	☐	☐
Hard to start urinary flow	☐	☐	Difficulty with ejaculation	☐	☐
Any leakage/incontinence of urine	☐	☐	Difficulty with orgasm	☐	☐
Pelvic pain	☐	☐	Pain on intercourse	☐	☐
Sexually transmitted disease	☐	☐	Any other sexual problems	☐	☐
10. FOR WOMEN					
Menstruation began _____			Number of: pregnancies _____ live births _____		
Menopause began _____			Last Pap smear _____		
Last menstrual period _____			Last mammogram _____		
Typical cycle is _____ days in length with menstrual period lasting _____ days.					

PHYSICIAN NOTES

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 to 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: _____

HOSPITAL FOR SPECIAL SURGERY

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 _____

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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.