ELIZABETH M. MANEJÍAS, M.D.

REGISTRATION FORM

DATE:___________________ **HSS#**____________________

PATIENT'S FULL NAME: ____

DATE OF BIRTH: _____________________ SSN _________________________ M / F

MARITAL STATUS: S / M / D /W (PLEASE SELECT ONE)

MAILING ADDRESS: ____

CITY: _________________________________ STATE: ______________ ZIP: ____________

HOME PHONE: ______________________ OFFICE: __________________ Ext: _________

EMAIL: _____________________________________ CELL: __________________________

NAME OF EMERGENCY CONTACT / RELATION: _______________________________

ADDRESS:____ PH#_______________________

NAME OF LEGAL GUARDIAN (if under 18 yrs): ___________________________________

CONTACT INFO: ____

PRIMARY INSURANCE: ___________________________POLICY #___________________

GUARANTOR NAME: ____________________________________ (Insurance Policy holder)

RELATIONSHIP TO PATIENT: _________________________ DOB: ____________________

ADDRESS: ____

CITY: _________________________________ STATE: _______________ ZIP: ____________

EMPLOYER: ____________________________OCCUPATION: ________________________

PRIMARY CARE DOCTOR:____

TEL: ______________________________ FAX: ______________________________

ADDRESS: ____

CITY: _________________________________ STATE: _______________ ZIP: ____________

REFERRING DOCTOR or SOURCE: ____

TEL: ________________________________ FAX: _____________________________

ADDRESS: ____

CITY: _________________________________ STATE: _______________ ZIP: ____________

Assignment and Release of Information statement: I certify that the information given by me is correct. I understand that this information is entered into a database and I hereby authorize the release of information related to my medical care as requested by government agencies and/or insurance carriers. I hereby assign benefits and understand that in the absence of accepted insurance coverage, I/Legal guardian am responsible for full payment of services rendered.
Medicare Patient: I understand that I am responsible for insurance deductibles on all services, 20% co-insurance on ancillary services. When Medicare is deemed the secondary insurance, I will follow payment terms under your policies.
Litigation Disclaimer: It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not requesting any information in connection with pending or proposed litigation.

Authorized Signature/Guardian:____Date:______________

Elizabeth M. Manejías, M.D.
635 Madison Avenue, 5th Floor, New York, NY 10022
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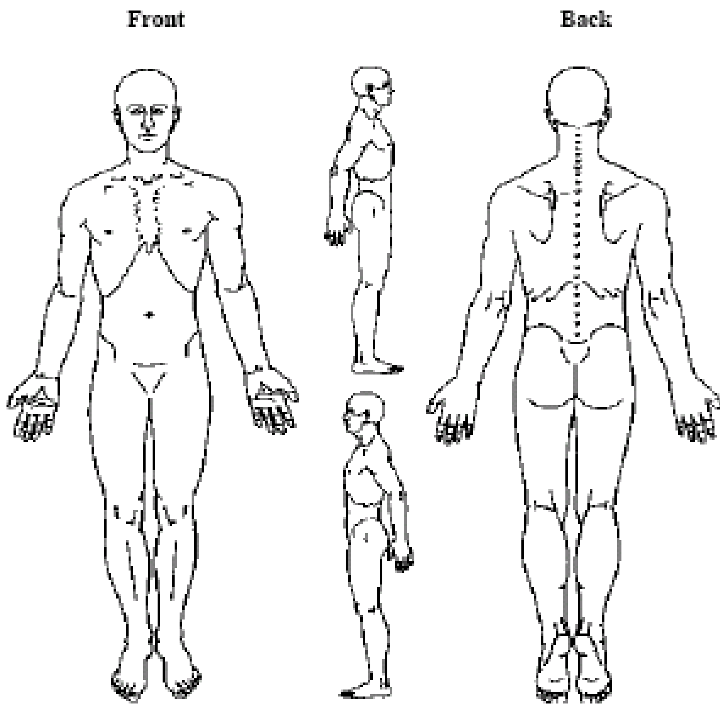
Integrative Care Center
Hospital for Special Surgery

New Patient Questionnaire

Name______________________________Age_______Birthdate_________________
Referred by (first and last name)______________________________________
Chief Complaint____
Date of injury or symptom onset:_______________________________________
Please describe the injury or problem: _______________________________
____



Where is your pain? Please mark the drawing.
Rate Your Pain:
0 = No pain 10 = Extreme pain

Please indicate your pain level

No Pain to Worst 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 make it better? ________________________
____
5. What makes it worse?________________________
____

Circle the words which best describe your symptoms:

Dull/Ache Shooting Awareness Sharp/Stabbing Gnawing Burning
Numbness Throbbing Heaviness Weakness Tightening/Constricting

What diagnostic tests have you had for this condition? (X-ray, MRI, EMG etc.) Date?
____
____

Please list all treatments that you have tried for your condition including physical/occupational therapy, massage, acupuncture, chiropractor, injections, and medications (please list type of injection and/or medications).
Circle which treatments have helped you the most.
____
____

Your Medical History
Please list any ongoing medical problems (High blood pressure, Diabetes, Thyroid disorder, Cancer, Bleeding disorder, Heart disorder, Asthma, Arthritis, Headaches)
____
____

Past SurgicalHistory____

Current Medications, Vitamins, or Nutritional Supplements_____________________________________
____

Are you allergic to any medication? Y N If yes, please list____________________________________

Gynecological History (if applicable)
Date of last menstrual period:_______________Age you began menstruating: ______________________
Have you experience menopause/hysterectomy? Y N If yes, when__________________________
How many periods have you had in the last 12 months?____________________________________
Do you use birth control? Y N If yes, what type____

Family History
Does anyone in your family have any of the following problems?
Heart disease High blood pressure Cancer Nerve problems Stroke Diabetes Blood problems Other____

Please Circle Current Symptoms or Problems
recent weight change dizziness loss of bowel control change in urinary habits fatigue
seizures muscle weakness visual changes constipation fever/chills chest pain
nausea/vomiting night pain headaches shortness of breath numbness
joint stiffness, pain or swelling depressed mood memory loss skin rash/disease

Are you under any emotional stress or suffer from anxiety or depression? If yes are you undergoing any treatment? ____

What is your occupation or former occupation? Are you retired or disabled?
____

Are you single, married, divorced, or a widow/widower?____

Who lives within your household?____

What type of physical activity do you do and for how many hours per week?
____

Do you smoke, drink alcohol, or use illegal substances? If yes, how often?
____

Do you consider your current weight ideal? Y N If not, what is your ideal weight? ______________
Do you have any questions about healthy ways to control your weight?_____________________________

What are your goals or expectations from our treatment?______________________________________
____

What specific issues would you like addressed today? ____________________________________
____

Elizabeth M. Manejías
635 Madison Avenue, 5th Floor
New York, NY 10022
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(F) 212-224-7956

Last Name:____________________________First Name_________________________________

Address________________________________City______________State______Zip__________

Sex:____________SS#_____________________________________D.O.B._______________

Telephone (H)___________________(W)______________________(C)____________________

Emergency contact_______________________________relation:_________________________

X-rays within 3-6 months_______Location____

Workers Compensation Information:

Case Manager:____Phone____________________

Insurance Carrier____________________________________Claim #:______________________

Address:_______________________________City_____________State______Zip___________

Date of injury:____________Address where injury occurred:_____________________________

City___________________State__________________Zip____________Time:_____________

No Fault Insurance Information

Name of Vehicle Ins. Company:____

Address______________________City:______________State_______________Zip_________

Name of Adjuster:________________________________Phone___________________________

Policy #:____ Claim #:________________________

Date of Accident:_________________________________Injury:__________________________