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

Nationality of Parents:

Could your parents have been related? yes no

Health status and age of Father (if dead; age of death and cause):

Health status and age of Mother (if dead; age of death and cause):

Health status and ages of brothers and sisters:

Health status and ages of children:

Do any members of your immediate or distant family have (circle all that are true): seizures/epilepsy, mental retardation, headaches, weakness, problems walking, wheelchair bound, peripheral neuropathy, muscular dystrophy, ALS, Alzheimer, Parkinson disease?

_____
_____
_____

SOCIAL, OCCUPATIONAL:

Occupation: _____ Spouse/Partner_____
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.

Name: **Date of Birth:**

Neurological Questionnaire (Review of Systems):

Circle your response as it applies in the question as well as yes/no

Do you have persistent numbness and tingling in the feet?	Yes	No
Do you have persistent numbness and tingling in the fingers?	Yes	No
Do you have problems with balance?	Yes	No
Have you ever fallen?	Yes	No
Number of falls in past 6 months _____		
Do you consistently trip on curbs, cracks in sidewalks, edges of carpets	Yes	No
Do you have a tremor in the arms? Worse at rest or during movement	Yes	No
Do you have muscle cramps?	Yes	No
Where _____?		
Do you have muscle pain, soreness, and stiffness?	Yes	No
Has you urine ever been the color of coca cola (almost black)?	Yes	No
Do your muscles twitch or move under your skin?	Yes	No
Where _____ ?		
Do you feel overly fatigued without energy?	Yes	No
Do you have difficulty climbing stairs, arising from chairs, exiting cars?	Yes	No
Do you have trouble with buttoning buttons, snapping snaps, zipping zippers?	Yes	No
Has your handwriting deteriorated?	Yes	No
Do you have trouble lifting your arms over your head (e.g. washing hair)?	Yes	No
Do you have low back pain?	Yes	No
Do you have neck pain?	Yes	No
Do you have neck stiffness?	Yes	No
Do you have tingling in your arms and legs when you touch your chin to chest?	Yes	No
Do you have moving pain from your neck/back into your arms/legs?	Yes	No
When you cough does pain in the arms or legs increase in intensity?	Yes	No
Do you have problems with bowel and bladder function?	Yes	No
Do you have problems with sexual function?	Yes	No
Do you have problems chewing, speaking, swallowing or breathing?	Yes	No
Do you have facial numbness?	Yes	No
Do you have problems hearing?	Yes	No
Do you have problems with dizziness?	Yes	No
Do you have double vision?	Yes	No
Do your eyelids ever droop?	Yes	No

Have you ever gone blind in one or both eyes? Yes No
Do you ever have nausea or vomiting with or without headache? Yes No
Have you ever had a seizure (convulsion)? Yes No
Have you ever blacked out? Yes No
Has memory loss ever had an impact on daily activities? Yes No
Has your personality changed recently? Yes No
Do you find yourself crying or laughing more easily or inappropriately? Yes No
Do you have headaches that interfere with daily activities? Take pain relievers? Yes No

General Health Questionnaire (General Review of Systems)
(circle all that apply; then explain)

General:
Have you had a change in appetite or weight. Yes No
Do you snore?
ENT: Do you have sinus or thyroid problems, sore throat, or swollen glands? Yes No
Pulmonary: Do you have problems coughing, producing sputum, blood, have
Asthma, or use a nebulizer Yes No
Cardiac: Do you have hypertension, chest pain, suffered a heart attack, have
Swelling in the ankles, or have to sleep on 2 or more pillows to breath? Yes No
GI: Do you have nausea, vomiting, abdominal pain, blood in your stools,
Constipation or incontinence? Yes No
GU: Do you have burning when you urinate, have blood in your urine, or
Incontinence? Yes No
Endocrine: Have you ever had problems with your thyroid? Have you had problem
With hair loss, unexplained weight gain or loss, loss of eyebrows? Yes No
Skin: Have you had changes in your ability to bruise, unusual rashes or
skin change? Yes No
Psychiatric: Have you ever been treated by a psychiatrist for depression or
any other problem? Yes No

DISCUSSION OF YOUR HEALTH INFORMATION TO OTHER INDIVIDUALS

I authorize Dale Lange, MD to discuss my personal health information with the following individuals:

_____ _____

_____ _____

_____ _____

Signature of patient:_____ Date:_____

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

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 _____

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

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

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.