

# 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 _____<br>Specialty: _____ | _____   | Tel ( ) _____<br>Fax ( ) _____ | <input type="checkbox"/> |
| Name _____<br>Specialty: _____ | _____   | Tel ( ) _____<br>Fax ( ) _____ | <input type="checkbox"/> |
| Name _____<br>Specialty: _____ | _____   | Tel ( ) _____<br>Fax ( ) _____ | <input type="checkbox"/> |
| Name _____<br>Specialty: _____ | _____   | Tel ( ) _____<br>Fax ( ) _____ | <input type="checkbox"/> |
| Name _____<br>Specialty: _____ | _____   | Tel ( ) _____<br>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 71<sup>st</sup> 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 71<sup>st</sup> 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 \_\_\_\_\_

HOSPITAL  
FOR  
**SPECIAL  
SURGERY**



Department of Neurology  
Hospital for Special Surgery  
525 East 71<sup>th</sup> 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.