Alana B. Levine, M.D.
Hospital for Special Surgery
535 East 70th Street, New York, N.Y. 10021
Tel 212.606.1461 ◆ Fax 212.774.2374

Patient Registration Form **Today's Date:**

Name:_____ Date of Birth:_____ Sex:_____

S.S. #:_____ Marital Status:_____ Email: _____

Address:_____ City/State/Zip#:_____

Home Phone:_____ Cell Phone:_____ Fax:_____

Occupation:_____

Employer:_____ Work Phone:_____

Address:_____ City/State/Zip#:_____

Emergency Contact:_____ Relationship: _____

Address:_____ City/State/Zip#:_____

Phone:_____

Insurance Information

Please check your insurance policy for a waiting period before coverage or pre-existing clauses. If your coverage is contingent on a second opinion or pre-authorization or pre-admission, it is your responsibility to inform us.

Primary Insurance:	**Secondary Insurance:**
Address:	Address:
City/State/Zip:	City/State/Zip:
Policy Holder:	Policy Holder:
DOB:	DOB:
Insured ID:	Insured ID:
Number:	Number:
Group Number/Name:	Group Number/Name:
If W/C, provide date of accident:	

Assignment Release of Information Statement: I certify that the information given by me is correct and hereby authorize the release of information related to my medical care as requested by government agencies and / or insurance companies. I hereby assign benefits to Dr. Levine and authorize payment directly to Dr. Levine for services rendered. Medicare requests that payment of authorized Medicare benefits be made on my behalf to Dr. Levine.

Signature:_____ **Date:**_____

Alana B. Levine, MD ◆ New Patient Questionnaire

Name:_____ Age:_____

1. Medications (include doses) you take now:

2. Drugs to which you are allergic (what happens?):

3. Please list any medical problems, including approximate dates of diagnosis:

4. Please list any surgeries you have had, including approximate dates:

5. Please list any hospitalizations:

6. What are you hoping to get out of your visit today?

Name:_____ Date of birth:_____

7. Please tell me about your family's health, with particular attention to autoimmune or musculoskeletal disease (arthritis, lupus, thyroid disorders, blood clots, multiple sclerosis, inflammatory bowel disease, etc.):

Mother's mother_____
Mother's father_____
Father's mother_____
Father's father_____

Mother_____
Father_____

Siblings_____
_____

Children_____
_____

8. Please tell me some personal facts:

Are you married? _____no_____yes
Are you employed outside the home? _____no_____yes
If so, what kind of work do you do?_____

Do you smoke? _____no_____yes
If you stopped, when? _____
Do you drink alcohol? _____no_____yes
If yes, how much and how often? _____

8. **FOR MEN** – Please tell me about your most recent screening tests:

	Date	Normal?	Notes:
PSA (prostate blood test)			
Colonoscopy			
Bone density test			

9. **FOR WOMEN** – Please tell me about your most recent screening tests:

	Date	Normal?	Notes:
Mammogram			
Pap smear/pelvic exam			
Colonoscopy			
Bone density test			

Name:_____ Date of birth:_____

10. **FOR BOTH** – Have you been diagnosed with any of the following:

	NO	YES	IF YES, please describe:
High blood pressure			
Heart attack or other heart problems			
Stroke or TIA (mini-stroke)			
Cancer			
Kidney problems (stones, nephritis)			
Thyroid condition			
Sexually transmitted infection (syphilis, gonorrhea, Chlamydia, HIV, HPV, etc.)			
Seizures			
Psychiatric condition			
Abnormal blood cell counts (low white blood cells or platelets, anemia)			

11. Have you experienced any of the following symptoms or problems?

	NO	YES	IF YES, please describe:
Fatigue			
Fevers, chills, or sweats			
Recent change in your weight			
Frequent headaches			
Hair loss			
Rash			
Problems when you go in the sun			
Dry eyes			
Red or painful eyes			
Change in your vision			
Problems with your ears			
Sores or ulcers in your nose			
Sinus problems			
Dry mouth			
Sores or ulcers in your mouth			
Problems with your teeth			
Difficulty swallowing			
Painful swallowing			
Swollen and/or tender lymph nodes			
Chest pain			
Shortness of breath			
Cough			
Fingers/toes change color in cold (Raynaud's)			
Abdominal pain			
Nausea or vomiting			
Diarrhea or constipation			
Blood or protein in your urine			
Weakness on one side of your body			
Persistent numbness or tingling			

Thank you for taking the time to fill out this form. I look forward to meeting you.

Patient Signature: _____ **Date:** _____

Reviewed by Dr. Levine: _____ **Date:** _____

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Patient Name:_____

Referring Physician: ☐ Check if there is none

Physician's Name:_____ Specialty:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone No.:_____ Fax:_____

Primary Care Physician: ☐ Check if there is none

Physician's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone No.:_____ Fax:_____

Other Physicians:

Physician's Name:_____ Specialty:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone No.:_____ Fax:_____

Physician's Name:_____ Specialty:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone No.:_____ Fax:_____

Physician's Name:_____ Specialty:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone No.:_____ Fax:_____