Patient Information

Name____ Soc.Sec. # ________________________________
Last Name First Name Initial
Address____Cell phone _________________________
City___________________________ State _______Zip _____________Home Phone ________________________
Sex ☐ M ☐ F Age _______ Birthdate__________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
E-mail address (optional)_____________________
Patient Employed by_____________________________________ Occupation
____
Business Address _____________________________________ __Business Phone ____________________________
Family or referring physician__________________ Address ____
Phone ____________________
Whom may we thank for referring you?____
In case of emergency who should be notified? ___________________________Phone ___________________________

Primary Insurance

Plan Name _____________________________________ Number ________________________
Plan Address ___________________________________ Group Number ____________________
Policy Holder Name _________________________________ Policy Holder' Date of Birth ____/_____/____
Last First
Policy Holder' Social Security Number ______-_______-__________ Relationship to Patient: ( ) self, ( ) spouse, ( ) parent, ( ) other _________________

Additional Insurance

Plan Name _____________________________________ Number ________________________
Plan Address ___________________________________ Group Number ____________________
Policy Holder Name _________________________________ Policy Holder' Date of Birth ____/_____/____
Last First

Pharmacy Information

Name of the Pharmacy ______________________________

Address ____
Street Address Apt City State Zip Code

Telephone number (_____)___________ Fax number (_____)___________

Please read the following disclosure carefully. Please note that your prescriptions may be submitted electronically to the pharmacy of your choice. You can change your designated pharmacy at any time. Controlled substances and some other medications that cannot be submitted electronically must be picked up in person (we will not mail, fax, email or call them in).

Signature______________________________ Name__________________________ Date__________
by signing this form I certify that I reviewed the above information and that all the above information is correct to the best of my knowledge

NYC MEDICAL AND NEURODIAGNOSTIC, P.C.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand NYC Medical and Neurodiagnostic's Notice of Information Practices. I understand that NYC Medical and Neurodiagnostic may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that NYC Medical and Neurodiagnostic will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in NYC Medical and Neurodiagnostic's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

______________________________________ ________________________________

______________________________________ ____________________

Patient or Guardian Signature Date

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:____________________________________ Relationship:____________________

Name: ____________________________________ Relationship: ____________________

____

Patient or guardian signature

INSURANCE/PAYMENT AUTHORIZATION FORM

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________________
Name of Insurance Plan

and assign directly to NYC Medical & Neurodiagnostic, PC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Appropriate efforts will be made by this office to bill my insurance, workman's comp, etc. if applicable, however I understand that co-pays, deductibles, and ultimately the total amount of my bill is my responsibility and I will be expected to settle my account in a timely manner. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize to use of this signature on all insurance submissions and permit copies of this authorization to be used in place of the original. Should any balance remain after 90 days, I will pay interest at the annual rate of 9% (0.75% per month) starting from the date the charges were made. I understand that delinquent accounts are turned over to a collection agency. If this account is assigned to an outside agency for collection, I agree to pay all attorney fees, court costs, and a collection agency fee of 40%, which will be added to the outstanding balance of my account with or without suit. I understand that some services are not covered by my medical insurance (including but not limited to performance and interpretation of medical tests, completion of various medical and/or legal forms, various letters). I will be charged for these services separately but I have a right to receive an estimate of charges prior to the work being performed.

Patient (or responsible party)/ Guardian signature: ______________________ Date: __________

Patient's Name ___________________________________

PATIENT'S PERSONAL HISTORY

Date __________

Confidential Record: Information contained here is kept confidential according to NYC Medical and Neurodiagnostic's Notice of Information Practices.

Please answer the following questions focusing on the <u>past 12 months</u>:

ALLERGY/ENDOCRINE/IMMUNOLOGIC/SKIN	Y	N
history of rashes	☐	☐
elevated Blood Glucose (sugar), diabetes	☐	☐
hair: unexplained loss/ growth	☐	☐
history of anemia	☐	☐
autoimmune diseases (e.g. Crohn's, Thyroid, Ulcerative colitis, Lupus, Rheumatoid arthritis, Sjogren's, Ankylosis spondylosis)	☐	☐
bleeding or clotting disorders	☐	☐

CARDIOVASCULAR	Y	N
heart disease or heart attack	☐	☐
palpitations/ irregular heartbeats	☐	☐
elevated Blood Pressure	☐	☐
elevated cholesterol	☐	☐
calf pain on walking that resolves with rest	☐	☐

GASTROINTESTINAL	Y	N
changes in appetite	☐	☐
difficulty with swallowing	☐	☐
frequent nausea or vomiting	☐	☐
constipation / diarrhea / incontinence	☐	☐

GENERAL HEALTH	Y	N
change in weight? Intentional / unintentional	☐	☐
perform usual daily activities without difficulty?	☐	☐
recent fevers or unexplained illnesses?	☐	☐
increasing fatigue or loss of energy?	☐	☐

GENITOURINARY	Y	N
incontinence/ loss of bladder function	☐	☐
pain / tingling with urination	☐	☐
kidney stones	☐	☐
Females:		
regular menstrual cycles	☐	☐

last period ____________________

HEAD/EYES/EARS/NOSE/THROAT	Y	N
dizziness/ Spinning sensation/ lightheadedness	☐	☐
fainting or loss of consciousness	☐	☐
change in vision/ partial loss / blurred / double	☐	☐
severe headaches	☐	☐

how often__________________

MUSCULOSKELETAL	Y	N
weakness in arms or legs?	☐	☐
loss of muscle mass (not due to lack of exercise)?	☐	☐
loss of motion in any joint	☐	☐
joints becoming increasingly painful	☐	☐
history of back pain: Neck / Mid / Low	☐	☐
new onset / increasing neck pain/ stiffness	☐	☐
drooping of one side of the face/ one eye	☐	☐

NEUROLOGIC	Y	N
seizures or staring spells	☐	☐
tremors	☐	☐
numbness or tingling	☐	☐
stroke or "mini stroke"	☐	☐
difficulties walking/ change in your gait	☐	☐
difficulty with speech/ finding/remembering words	☐	☐

PSYCHIATRIC	Y	N
history of depression and/or anxiety	☐	☐
history of hallucinations	☐	☐
overall change in your mood	☐	☐
changes to memory: short term / long term	☐	☐

RESPIRATORY	Y	N
shortness of breath with activity/ at rest	☐	☐
coughing up blood/ had blood in the sputum	☐	☐