

PLEASE FAX THIS DOCUMENT TO 516-354-8597 PRIOR TO YOUR APPOINTMENT

LONG ISLAND NEUROSURGICAL ASSOC., P.C.

APPOINTMENT DATE \_\_\_\_\_

WHICH PHYSICIAN \_\_\_\_\_

**PATIENT INFORMATION**

PATIENT'S FULL NAME \_\_\_\_\_ D/O/B \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_ SEX \_\_\_  
HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_ ZIP \_\_\_  
HOME TEL# (\_\_\_\_) \_\_\_\_\_ BUSINESS TEL# (\_\_\_\_) \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_ ZIP \_\_\_  
(For Hospital Purposes) MOTHER'S NAME \_\_\_\_\_ FATHER'S NAME \_\_\_\_\_  
MARITAL STATUS \_\_\_ SPOUSE'S NAME \_\_\_\_\_ PATIENT'S SS# \_\_\_\_\_  
IF PATIENT IS A MINOR, FATHER'S SS# \_\_\_\_\_ MOTHER'S SS# \_\_\_\_\_  
REFERRING PHYSICIAN \_\_\_\_\_  
ADDRESS \_\_\_\_\_ TELEPHONE# \_\_\_\_\_

**MEDICAL INFORMATION**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

PRESENT COMPLAINT \_\_\_\_\_  
DATE OF ONSET \_\_\_\_\_ IF DISABLED, EXACT DATE IT BEGAN \_\_\_\_\_  
HAVE YOU HAD PRIOR RELATED SURGERY, WHEN, BY WHOM \_\_\_\_\_  
DID YOU SUSTAIN TYPE OF INJURY/DATE \_\_\_\_\_ AUTO \_\_\_\_\_ WORK \_\_\_\_\_ HOME \_\_\_\_\_ OTHER \_\_\_\_\_  
INDICATE DATE OF ACCIDENT AND BRIEF EXPLANATION \_\_\_\_\_  
INDICATE ANY MEDICATIONS YOU ARE TAKING \_\_\_\_\_  
ARE YOU ALLERGIC TO ANYTHING? \_\_\_\_\_ DO YOU SMOKE ? \_\_\_\_\_  
ARE YOU RIGHT HANDED? \_\_\_\_\_ OR LEFT HANDED? \_\_\_\_\_ BOTH? \_\_\_\_\_

IF **YOU** HAVE HAD ANY OF THE CONDITIONS BELOW PLEASE **CIRCLE**, IF A **BLOOD RELATIVE** HAS HAD ANY OF THE CONDITIONS PLEASE **CHECK**:

ARTHRITIS \_\_\_ HYPERTENSION \_\_\_ ASTHMA, HAY FEVER, HIVES \_\_\_ STROKE \_\_\_ CANCER \_\_\_  
DIABETES \_\_\_ DEPRESSION \_\_\_ SUICIDE \_\_\_ LIVER DISEASE \_\_\_ ANEMIA \_\_\_  
BLEEDING TENDENCY \_\_\_ KIDNEY DISEASE \_\_\_ MIGRAINES \_\_\_ BRAIN TUMOR \_\_\_ GOUT \_\_\_  
THYROID DISEASE \_\_\_ SEIZURES \_\_\_ ULCERS \_\_\_ LUPUS \_\_\_ MULTIPLE SCLEROSIS \_\_\_  
OTHER(S) NOT LISTED ABOVE \_\_\_\_\_  
ARE YOU ALLERGIC TO SEAFOOD OR IODIDES? \_\_\_\_\_  
HAVE YOU EVER HAD A POOR REACTION TO A DIAGNOSTIC TEST (IF SO, INDICATE WHAT TYPE OF TEST AND WHAT OCCURRED) \_\_\_\_\_

**INSURANCE INFORMATION: MUST BRING ALL INSURANCE CARDS & REFERRALS TO SCHEDULED APPOINTMENT(S)**

FULL NAME OF POLICY HOLDER \_\_\_\_\_  
NAME OF INSURANCE COMPANY AND ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
POLICY ID NUMBER(S) \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
IF APPLICABLE, NAME OF SECOND POLICY HOLDER \_\_\_\_\_  
NAME OF INSURANCE COMPANY AND ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
POLICY ID NUMBER(S) \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
EFFECTIVE DATE OF MEDICARE \_\_\_\_\_  
DO YOU HAVE MEDICARE \_\_\_\_\_ PART A \_\_\_ PART B \_\_\_ ID# \_\_\_\_\_  
IF YOU HAVE SECONDARY COVERAGE INDICATE INSURANCE COMPANY NAME AND ID# \_\_\_\_\_

DO YOU HAVE MEDICAID? \_\_\_\_\_ ID NUMBER \_\_\_\_\_ SEQUENCE NUMBER \_\_\_\_\_  
IF YOU ARE COVERED BY WORKER'S COMPENSATION AND/OR NO-FAULT PLEASE ASK FOR ADDITIONAL PROFILE(S) AT OFFICE AND BRING ALL BILLING INFORMATION