LINA
LONG ISLAND
NEUROSURGICAL ASSOCIATES

Steven J. Schneider, MD
Mark A. Mittler, MD
Michael A. Lefkowitz, MD
Shaun D. Rodgers, MD
Shanna L. Baron, FNP-C

PLEASE FILL OUT FORM BELOW AND THEN FAX BACK TO: 516-354-8597

ADDITIONALLY, PLEASE BRING FORM WITH YOU ON THE DAY OF YOUR SCHEDULED APPOINTMENT.

THANK YOU

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NEW PATIENT MEDICAL INFORMATION

Patient Name:____ Today's Date:_______________________
Gender: Male [ ] Female [ ] Date of Birth:_____________ Age:_________ Height:__________ Weight:___________
Race: o American Indian or Alaskan Native o Asian o Black or African-American o More Than One Race
o Native Hawaiian o Other Pacific Islander o White o Refused to Report/Unreported
Ethnicity: o Hispanic or Latino o Non-Hispanic or Latino o Refused to Report/Unreported
Language: o English o Spanish o Other: ____

Reason for Consultation (include symptoms / signs if any):____
____
____
____
____
Date of Onset (may approximate):____

Previous/Existing Medical Conditions (list):____
____
____
Previous Surgical Procedures (list with approximate dates):____
____
____

Current Medications (with dosages):____
____
Local Pharmacy: ______________________ Town: ______________________ Telephone Number:(_____) _______- ________

Mail Order Pharmacy: ____ Telephone Number: (_______) ________ - __________

Medication or Environmental Allergies (list with symptoms / signs):____
____

Family History – Please indicate any relevant family history and which family members it pertains to:__________________
____
____
Social History:
Dominant Hand: o Right handed o Left handed o Ambidextrous
Are you currently enrolled in school? If so, what grade or level?____
Do you participate in any physical activities? o Yes o No
If so, what types of activities?____
Please describe your Current Tobacco Use? o Smoker, current status unknown o Light tobacco smoker o Heavy tobacco smoker
o Current everyday smoker o Current some day smoker o Former smoker o Never smoker o Unknown if ever smoked
If past history of smoking or current smoker, please indicate: Packs per day_____________ Total Amount of Years Smoked ______
I certify that the above information is accurate to the best of my knowledge: Signature **X**________________________________

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REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor or nurse practitioner will discuss any positive responses with you.

General:
- ❑ Chills
- ❑ Fever
- ❑ Night Sweats
- ❑ Significant Weight Change
- ❑ Other: _______________

Skin:
- ❑ Bruising
- ❑ Dryness
- ❑ Excessive Sweating
- ❑ Hair Loss
- ❑ New Lesions
- ❑ Rash
- ❑ Other: _______________

HEENT:
- ❑ Blurred Vision
- ❑ Hearing Loss
- ❑ Seasonal Allergies
- ❑ Other: _______________

Neck:
- ❑ Neck Mass
- ❑ Swollen Glands
- ❑ Other: _______________

Respiratory:
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Sleep Apnea
- ❑ Wheezing
- ❑ Other: _______________

Cardiovascular:
- ❑ Anemia
- ❑ Bleeding Tendency
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Leg Pain and/or Swelling
- ❑ Other: _______________

Gastrointestinal:
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting
- ❑ Other: _______________

Genitourinary:
- ❑ Frequency
- ❑ Incontinence
- ❑ Painful Urination
- ❑ Other: _______________

Musculoskeletal:
- ❑ Upper Back Pain
- ❑ Lower Back Pain
- ❑ Joint Swelling
- ❑ Other: _____________

Hematology:
- ❑ Anemia
- ❑ Blood Clots
- ❑ Easy Bruising
- ❑ Easy Bleeding
- ❑ Enlarged Lymph Nodes
- ❑ Other: _______________

Neurological:
- ❑ Fainting
- ❑ Difficulty Walking
- ❑ Dizziness
- ❑ Headache
- ❑ Loss of Consciousness
- ❑ Migraines
- ❑ Numbness
- ❑ Weakness
- ❑ Seizures
- ❑ Tingling
- ❑ Other: _______________

Endocrine/Glands:
- ❑ Appetite Changes
- ❑ Excessive Urination
- ❑ Thyroid Problems
- ❑ Other: _______________

Psychiatric:
- ❑ Anxiety
- ❑ Depression
- ❑ Easily Irritated
- ❑ Memory Loss
- ❑ Suicidal Thoughts
- ❑ Other: _______________

□ **None of the Above**

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NEW PATIENT DEMOGRAPHICS

Patient:

Name (Last, First): ____ Date of Birth: _______________________ Age: ________

Home Telephone Number: (________) ________ -__________ **Cell Phone Number**: (________) ________ -____________

Home Address (Street, City, State, Zip): ____

____

____

Email Address: ____

Profession, Workplace Name: ____

Work Telephone Number: (________) ________ - __________

Lives with (circle): Spouse(or significant other) / Mother / Father / Both / Other

Spouse/Significant Other:

Name (Last, First): ____ Relationship:______________________________

Home Telephone Number (Leave blank if same as patient): (________) ________ -____________

Home Address (Street, City, State, Zip) (Leave blank if same as patient): ____

____

____

Profession, Workplace Name: ____

Work Telephone Number: (________) ________ -____________

Cell Phone Number: (________) ________ -____________

Emergency Contact:

Name (Last, First):____ Relationship:__________________________________

Home Telephone Number (Leave blank if same as patient): (________) ________ -____________

Home Address (Street, City, State, Zip) (Leave blank if same as patient):____

____

____

Profession, Workplace Name:____

Work Telephone Number: (________) ________ -____________

Cell Phone Number: (________) ________ -____________

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NEW PATIENT DEMOGRAPHICS

Primary Care Provider: Name:____
Telephone Number: (________) ________ -____________ Fax Number: (________) ________ -____________
Address (Street, City, State, Zip): ____
____
____

Other Physician: (Specialty (ie: Neurology): ____)
Name:____
Telephone Number: (________) ________ -____________ Fax Number: (________) ________ -____________
Address (Street, City, State, Zip): ____
____
____

Other Physician: (Specialty(ie: Pain Management): ____)
Name:____
Telephone Number: (________) ________ -____________ Fax Number: (________) ________ -____________
Address (Street, City, State, Zip): ____
____
____

Other Physician: (Specialty (ie: Cardiology or Other): ____)
Name:____
Telephone Number: (________) ________ -____________ Fax Number: (________) ________ -____________
Address (Street, City, State, Zip): ____
____
____

INSURANCE INFORMATION
*****WE MUST MAKE A COPY OF ALL INSURANCE CARDS*****

PRIMARY Insurance:____
Full name of policy holder:____ **Date of Birth:**________________
Policy ID Number:_____________________________ **Group Number**__________________________________
Employer:____
SECONDARY Insurance:____
Full name of policy holder(if different from above):___________________________ **Date of Birth:**________________
Policy ID Number_____________________________ **Group Number**__________________________________

RELEASE

***Your Signature here allows for the RELEASE of medical information to your insurance company and for the direct assignment of benefits to our provider* X**____ Date_____________________