ORTHOPEDIC SPINE CARE OF LONG ISLAND, P.C.

Patient Information and History Form

Date: ______________________________

Patient Personal Information Marital Status: _____Single _____ Married ____Widowed Sex: ___M __F

Name: ____ Home Phone:____

Street Address: ____ Work Phone:____

City: __________________ State: ________Zip_____________ Date of Birth: ____

Employer: ____ SSN#: ____

Address: ____ Primary Care Physician : ____________________________

Phone: ____ Address/Phone: ____________________________________

Patient Insurance Information Referred by: ____

Primary Insurance Company ____

Address ____ City ________________ State ____________ Zip ________

Insured's Name : ____ Date of Birth _______________ SSN# ___________________

Identification # ____ Group ID____

Relationship to Patient _________________ Employer ____________________________________

Secondary Insurance Company ____

Address ____ City ________________ State ____________ Zip ________

Insured's Name : ____ Date of Birth __________________ SSN# __________________

Identification # ____ Group ID ____

Relationship to Patient ___________________ Employer __________________________________

Accident Information

Is condition due to an accident ? ____ YES ____ NO Date _________

Type of Accident ____Auto ____ Work ____Home Other ________

Assignment and Release

I hereby authorize the physician(s) of Orthopedic Spine Care of Long Island, P.C., to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependent for purposes of review, investigation or evaluation of claims.

I authorize payment of medical benefits to the physician(s).

Patient or Authorized Signature ____

Physician's Signature ____

In case of denial or termination of benefits, I the undersigned, understand that I am responsible for payment in full for services rendered.

Patient or Authorized Signature ____ Date ________

BP ______________________ **Pulse** ______________________ **Date** ________________________

ORTHOPEDIC SPINE CARE OF LONG ISLAND, P.C.
PATIENT REGISTRATION FORM

Age ______________________ Height ________________________ Weight _______________

Patient Name ____

Doctor Requesting Consult ____
Name/ Address ____
____

Is there someone you would like to send a report of your visit to?
Name/Address ________________________________ Name/Address ______________________________
________________________________ ______________________________
________________________________ ______________________________

HISTORY OF PRESENT ILLNESS

Chief Complaint: (Reason for being seen) List detailed symptoms, location and description of pain.
Example: I am having pain in my lower back with radiation down to my knees.

____
____
____

When did present episode of pain begin? ____
Where and How did this episode start? ____
Have you ever had anything like this before? If yes, when ? How? ____

Neck/Upper Back

Have you experienced arm and hand numbness/weakness? _____YES _____NO
Based on a total of 100%. What percentage of your pain is in your ______% neck vs. _____% arms.

Mid/Lower Back

Have you experienced leg numbness/weakness? ____ YES ____ NO
Based on a total of 100%. What percentage of your pain is in your ______% back vs. _____ % legs.

1) What makes the pain worse?

____ sitting ___ standing ____ walking
____ bending forward ___ bending backward ____ coughing

2) What reduces the pain?

____ sitting ____ standing ____ walking
____ medications ____ exercise ____ lying down

PAST MEDICAL TREATMENT

Have you been treated by another doctor for this injury or complaint? ___YES ___ NO
If yes, please list the doctors name and location

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Have you had any diagnostic test performed for this problem?

TEST	***DATE (s)***	***TEST***	***DATE(s)***
X-RAYS		BONE SCAN	
MRI		DISCOGRAM	
MYELOGRAM		CAT SCAN	
DEXASCAN		OTHER	

What other treatments have you tried for your problem/complaint?

TREATMENT	***DATE(s)***	***TREATMENT***	***DATE(s)***
PHYSCIAL THERAPY		CHIROPRACTIC	
ACCUPUNCTURE		SURGERY	
EPIDURAL STEROIDS		PAIN MANAGEMENT	
OTHER			

PAST HEALTH HISTORY : **Please check any of the following:**

√			√	
	ASTHMA			KIDNEY DISEASE
	ANGINA			ARTHRITIS
	DIABETES			STROKE
	CANCER			HEPATITIS
	TUBERCULOSIS			LIVER DISEASE
	HEART DISEASE			THYROID
	HIGH BLOOD PRESSURE			STOMACH ULCERS
	LUNG DISEASE			BLOOD CLOTS
	ANEMIA			SEIZURES
	OTHER			OTHER

SURGERIES, HOSPITALIZATION, SERIOUS INJURIES

Have you ever had **SPINAL SURGERY?** Please list dates, procedure and surgeon.

____

____

____

Please list other SURGERIES that you have had. Please include date, procedure and surgeon**.**

____

____

____

MEDICATIONS : Please list all current medications you are taking. This includes all prescription, over the counter and herbal medications.

____

____

____

ALLERGIES: Are you allergic to ANY medication? YES NO If yes, please list below.

____

____

____

____

Do you have an Allergy to Latex? YES NO

Do you have an Allergy to shellfish, iodine or x-ray contrast ? YES NO

FAMILY HISTORY

Please check any of the below which apply to your family history?

	YES	NO	SPECIFY RELATIONSHIP AND DATES
ARTHRITIS			
CANCER			
HEART DISEASE			
OSTEOARTHRITIS			
BACK PROBLEMS			
DIABETES/THYROID			
HIGH BLOOD PRESSURE			
NEUROLOGIC DISEASE			
SCOLIOSIS			

WORK HISTORY

Occupation: ____

Employer Name/Address ________________________________
____
____

Are you currently working? YES NO

____ FULL TIME _____ PART TIME ____ UNABLE TO WORK
____ UNEMPLOYED _____ RETIRED ____ ON DISABILTY

How many days have you missed in the past year due to your spine problem? _______________

SOCIAL HISTORY

- Education: (Grade School - Middle School - High School - College - Graduate Student)
- Marital Status: (Single - Married - Widow - Divorced)
- Number of Children? ____________
- Do you smoke? ______ YES _______ NO If yes, ________ Pack(s)/day. How many years? _______
- Did you previously smoke? ______ YES _______ NO If yes, ________ Pack(s)/day. How many years? _______
- Do you drink alcoholic beverages? _____ YES _____ NO How much? ___________________
- Do you now, or have you ever taken illicit intravenous drugs? _____ YES ______ NO

REVIEW OF SYMPTOMS: **please check all symptoms you have experienced in the past 2 months.)**

A. General: ____fever/chills ____weight loss ____other:________________________

B. Eyes: ____vision loss ____glasses/contacts ____other:________________________

C. ENT: ____hearing loss ____dentures ____other:________________________

D. Cardiac: ____chest pain ____palpitations ____other:________________________

E. Respiratory: ____shortness of breath ____cough
____wheezing ____other:________________________

F. GI: ____bowel dysfunction (incontinence) ____nausea/vomiting
____rectal bleeding ____other:_________________________

G. GU: ____bladder dysfunction (incontinence) ____frequency
____painful voiding ____other:________________________

H. Musculoskeletal: ____joint pain ____joint swelling
____morning stiffness ____other:_________________________

I. Skin: ____rashes ____lesions
____itching ____other:_________________________

J. Neuro: ____balance difficulties ____seizure
____headache ____other:_________________________

K. Psych: ____depression ____anxiety
____mania ____other:_________________________

L. Hematologic/Lymphatic: ____bleeding tendency ____bruising
____swollen glands ____other:_________________________

M. Allergies/Immunologic:
____decreased immunity ____frequent infections
____other:_________________________

My signature signifies that I have read, answered and understand the above information to be true and accurate.**
Patient/Guardian signature: ____

Physician use only: (Comments/Notes)