Brain & Spine Specialists Date: _____

INITIAL VISIT INFORMATION

NAME: _____ DOB: _____ AGE: _____

REASON FOR VISIT (*Please be specific)* _____

_____

Have you completed Physical Therapy for this condition? ☐YES ☐NO

Have you completed Pain Management Treatment for this condition? ☐YES ☐NO

Do you have a pacemaker or AICD? ☐YES ☐NO

MEDICAL HISTORY

Select and list relevant medical conditions:

☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Cancer
☐ Diabetes
☐ Emphysema
☐ Stents
☐ Epilepsy
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Neurologic Disorder

☐_____

SURGICAL HISTORY

List all surgeries you have undergone with dates:

_____

_____

_____

_____

_____

MEDICATIONS

List all medications you are taking:

_____

_____

_____

_____

_____

_____

ALLERGIES

Medications, food, contact, environmental:

_____

_____

_____

_____

☐Adverse reaction to CT or MRI contrast (dye)

☐Adverse reaction of Anesthesia

FAMILY HISTORY

Select and list all that apply:

☐ Asthma
☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Kidney Disease
☐ Strokes
☐_____

RELATED HEALTH

Are you a smoker? ☐YES ☐NO
Do you drink alcohol regularly? ☐YES ☐NO
Do you use drugs? ☐YES ☐NO

SOCIAL HISTORY

Are you currently working? ☐YES ☐NO
Occupation: _____
Do you have children? ☐YES ☐NO
Are you currently pregnant? ☐YES ☐NO

Please turn page over and continue on reverse side

REVIEW OF SYSTEMS
Check all that apply:

GENERAL · CONTSTITUTIONAL
- ☐ Weight loss
- ☐ Weight gain
- ☐ Decreased energy
- ☐ Fever
- ☐ Sweats

SKIN · BREAST
- ☐ Rash
- ☐ Itching
- ☐ Skin infections
- ☐ Sore that won't heal
- ☐ Hives
- ☐ Change in mole
- ☐ Change in skin or hair texture
- ☐ Hair loss
- ☐ Abnormal hair growth
- ☐ Nail changes
- ☐ Breast lumps, tenderness, swelling
- ☐ Nipple discharge

EYES · EARS · NOSE · MOUTH · THROAT
- ☐ Headaches
- ☐ Vertigo
- ☐ Lightheadedness
- ☐ Worsening of vision
- ☐ Double vision
- ☐ Blind spots
- ☐ Flashes, haloes, floaters
- ☐ Nosebleeds
- ☐ Fluid from nose or ears
- ☐ Dental infections
- ☐ Recurrent ear infections
- ☐ Dentures
- ☐ Loss of hearing
- ☐ Trouble swallowing
- ☐ Change in voice

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Rapid heart beat
- ☐ Irregular heart beat
- ☐ Heart murmur
- ☐ Fainting
- ☐ Shortness of breath with activity
- ☐ Shortness of breath while lying flat
- ☐ Swelling in ankles
- ☐ Poor circulation
- ☐ Varicose veins
- ☐ Blood clots in legs
- ☐ High blood pressure

RESPIRATORY
- ☐ Shortness of breath
- ☐ Pain with breathing
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Asthma
- ☐ Blood clots in lungs
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Indigestion, heartburn
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Incontinence of stool

GENITOURINARY
- ☐ Urgency
- ☐ Frequency
- ☐ Painful urination
- ☐ Lack of bladder control
- ☐ Incontinence of urine
- ☐ Urinary retention
- ☐ Urinary tract infection
- ☐ Blood in urine
- ☐ Problems with erections
- ☐ Loss of libido
- ☐ Irregular menstruation
- ☐ Painful menstruation
- ☐ Genital sores
- ☐ Genital discharge

MUSCULOSKELETAL
- ☐ Painful muscles or joints
- ☐ Loss of muscular strength
- ☐ Broken bones
- ☐ Osteoporosis (weak bones)
- ☐ Arthritis
- ☐ Muscle cramping
- ☐ Decrease in muscle size

NEUROLOGIC
- ☐ Convulsions
- ☐ Paralysis
- ☐ Tremor
- ☐ Incoordination
- ☐ Tingling
- ☐ Numbness
- ☐ Memory loss
- ☐ Difficulties with speech
- ☐ Stroke
- ☐ Seizures
- ☐ Multiple sclerosis
- ☐ Parkinson's disease

ALLERGIC · IMMUNOLOGIC
- ☐ Reactions to medicines
- ☐ Immune deficiency
- ☐ AIDS
- ☐ Multiple allergies

HEMATOLOGIC · LYMPHATIC
- ☐ Anemia
- ☐ Blood transfusion
- ☐ Easy bruising
- ☐ Bleeding tendency
- ☐ Blood clots
- ☐ Lymph node enlargement
- ☐ Tender lymph nodes

ENDOCRINE
- ☐ Increased thirst
- ☐ Intolerance to heat
- ☐ Intolerance to cold
- ☐ Hormone therapy

PSYCHIATRIC
- ☐ Depression
- ☐ Nervousness
- ☐ Anxiety
- ☐ Emotional problems
- ☐ Previous psychiatric care
- ☐ Unusual perceptions
- ☐ Hallucinations

Neurological Surgery & Pain Management 380 Montauk Highway, West Islip, NY 11795 631-422-5371

Name _____ Date of Birth _____/_____/_____ Age_____ M / F

Address _____City/State/Zip _____

SS# _____-_____-_____ Marital Status S M W D S Email _____

Preferred Contact Method			Message? (Y or N)
☐	Primary Phone	(_____) _____	Y N
☐	Other Phone	(_____) _____	Y N

I authorize my physician and the medical staff to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Contact Information

Referring Doctor Name_____ Telephone #_____

Primary Care Physician _____ Telephone # _____

Pharmacy and Location _____ Telephone # _____

How did you hear about our office? (Circle One) **Friends/Family** **Website/Google** **Newspaper** **Radio** **TV** **Direct Mail**

INSURANCE INFORMATION **If Change of Insurance: Effective DATE_____**

Primary Insurance _____ Member ID #_____

Policy Holder _____ Policy Holder SS# _____ Policy Holder DOB _____

Relationship to Patient _____ Policy Holder Employer_____

Secondary Insurance _____ ID # _____ Policy Holder _____

Policy Holder SS#_____ Policy Holder DOB _____ Relationship to Patient _____

WORKERS COMPENSATION or NO FAULT <u>OR</u> THIS IS NOT RELATED TO A CAR ACCIDENT OR INJURY AT WORK _____(initial)

Insurance Carrier_____ Claim Number_____

Date of Injury/Accident_____ Adjuster _____ Phone _____

Workers Compensation Only:

Employer _____ Employer Address_____

Job Title/Description_____ How did injury occur_____

On the date of injury, what were your usual work activities: _____

Attorney's Name & Phone Number _____

_____ _____

Signature of Patient **Date**

OVER →

I hereby authorize as follows:

I hereby authorize and direct William E. McCormick, MD (herein referred to as "the provider,") having treated me, to release to Medicare, Medicaid, governmental agencies, insurance carriers, or others who are financially liable for medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment.

I hereby guarantee payment to the provider of all charges and fees incurred for services rendered to me. I understand that if an insurance company (non-participating) fails to pay all or part of this claim, that I am responsible, upon notice, for payment in consideration of the physician's services which have been or will be provided to the patient. I hereby assign to the provider all of the medical insurance benefits to which I may be entitled from Medicare, Medicaid, governmental agencies, insurance carriers, no-fault carriers, or others that are financially liable for my care. I hereby authorize to the provider authority to file claims for payment and appeals on determinations of those claims on my behalf.

I hereby designate, authorize, and convey to the provider, having treated me to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy including fines.

I request that payment of authorized benefits be made on my behalf to the provider.

_____ _____

Signature of Patient Date

_____ _____

Signature of Person/Guarantor (Other than Patient) Witness

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediates of carriers any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.

_____ _____

Signature of Insured or Authorized Representative Date