

PATIENT INFORMATION

*****PLEASE COMPLETE ALL INFORMATION REQUESTED FOR OUR RECORDS*****

Date: _____

Name: _____ Date of Birth: _____ Age _____ Sex _____

Address: _____ Town _____ Zip _____

Phone # (H) _____ Social Security # _____

Phone # (W) _____ Divorced _____ Single _____ Married _____ Widow _____

Cell Phone# _____

Referring Physician _____ Phone # () _____

Address _____ Town _____ Zip _____

Family Physician _____ Phone # () _____

Address _____ Town _____ Zip _____

Other Health Care Providers _____ Phone # () _____

Address _____ Town _____ Zip _____

Employed by _____ Occupation _____

Address _____ Town _____ Zip _____

IN CASE OF EMERGENCY, CONTACT: _____ Phone # () _____

INSURANCE INFORMATION

MEDICARE Policy Holder Name _____ Medicare ID Number _____

MEDICAID Policy Holder Name _____ Medicaid ID Number _____

PRIVATE Policy Holder Name _____ Date of Birth _____ S.S. # _____

Insurance Company Name _____ Address _____

ID# or Policy Number _____ Local Group Number _____

I understand and agree that copies of your report and/or medical records will be made available to my referring physician and other treating healthcare providers. (If you have a specific request not to send a report and/or medical records, please write doctor's names below).

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information pertinent to my case to and from any physicians, insurance company, adjuster, or attorneys involved in this case. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance company, regardless of my insurance status. A photocopy of this release shall be considered as effective and valid as the original.

Patient (or authorized signature)

Date Signed

LKBN Neurology Associates--New Patient Medical History Form

Last Name: _____ First: _____ M.I. _____ Date: _____

Phone #: _____ DOB: _____ Age: _____ Sex: _____

Which hand do you write with? Right Left

PLEASE TELL US YOUR REASON FOR TODAY'S VISIT. PLEASE INCLUDE A DESCRIPTION OF YOUR SYMPTOMS, WHEN THEY BEGAN, AND IF YOU HAVE HAD THEM PREVIOUSLY.

PAST MEDICAL AND SURGICAL HISTORY: (Check all that apply)—include medical diagnoses, operations, hospitalizations

- Stroke _____
- Seizures _____
- Brain Surgery _____
- Neck/Back Surgery _____
- Other Neurologic Conditions _____

- Diabetes Heart Disease Peptic Ulcer Any metal in your body?
- High Blood Pressure Pacemaker/Defibrillator Cancer/Tumor _____
- High Cholesterol Atrial Fibrillation Depression/Anxiety _____

Other: _____

MEDICATIONS: (please list all prescription and over-the-counter medication, including Aspirin)

- 1. _____ 5. _____ 9. _____
- 2. _____ 6. _____ 10. _____
- 3. _____ 7. _____ 11. _____
- 4. _____ 8. _____ 12. _____

ALLERGIES TO MEDICATIONS?

Can you tolerate Aspirin? Yes No

FAMILY MEDICAL HISTORY: list any illnesses (especially neurological problems) that your blood relatives have had.

LKBN Neurology Associates
******PLEASE COMPLETE OTHER SIDE******

Name: _____ Date: _____

SOCIAL HISTORY

Occupation: _____ Disabled? _____

Tobacco: _____ Other recreational drugs: _____

Alcohol: _____

Marital Status: _____ Who do you live with? _____

How many children do you have? _____ Ages: _____

REVIEW OF SYSTEMS:

Please list any symptoms or problems and explain in the space provided.

If applicable:

Last Menstrual Period _____ **Height** _____

Please indicate if you might be pregnant Yes No **Weight** _____

<p>1. General</p> <p><input type="checkbox"/> None</p>	<p>7. Urinary</p> <p><input type="checkbox"/> None</p>
<p>2. Head/Ear/Nose/Throat</p> <p><input type="checkbox"/> None</p>	<p>8. Integumentary (Skin/Breast)</p> <p><input type="checkbox"/> None</p>
<p>3. Eyes</p> <p><input type="checkbox"/> None</p>	<p>9. Endocrine</p> <p><input type="checkbox"/> None</p>
<p>4. Cardiac</p> <p><input type="checkbox"/> None</p>	<p>10. Allergy/Immunologic</p> <p><input type="checkbox"/> None</p>
<p>5. Respiratory</p> <p><input type="checkbox"/> None</p>	<p>11. Neurological/Musculoskeletal</p> <p><input type="checkbox"/> None</p>
<p>6. GI</p> <p><input type="checkbox"/> None</p>	<p>12. Psychological/Psychiatric/Recent Stress</p> <p><input type="checkbox"/> None</p> <p>13. Symptoms or Disease not listed?</p>

SIGNATURE _____

DATE SIGNED: _____

LKBN Neurology Associates

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887-0331

AUTHORIZATION FOR RELEASE INFORMATION

By my signature below, I acknowledge that I have received a paper copy of LKBN Neurology Associates Notice of Privacy Practices. I hereby authorize the Practice to use or disclose to the recipient my health information, for the term of this Authorization. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health condition. I consent to release health information for the following specific purposes:

The Practice may use your health information or share it with doctors, nurses or other personnel within this office for the purpose of diagnosing or providing you treatment. In addition, the Practice may provide protected health information to other healthcare providers in order for them to provide you with care and treatment.

The practice may use or disclose PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure.

If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

The Practice may use your health information for disclosures to accreditation organizations - all relevant information requested consistent with the organizations' protocols and methodologies;

For disclosures to attorneys - all relevant information requested by attorneys;

For disclosures to risk managers at malpractice insurance companies;

For disclosures to transcriptionists - all information that needs transcribing, as well as any documents useful to ensuring the accuracy of those transcriptions;

For disclosures to a clinical laboratory or other entity performing diagnostic testing information relevant to performing the test or study that is requested;

For disclosures to collection agencies - all relevant information required to collect any outstanding debt;

For disclosures to an insurance company - all relevant information required to obtain payment for my healthcare bills;

For billing, coding, or practice management consultants - all relevant information consistent with their protocols or methodologies.

I also understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization, the Practice cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I hereby authorize the use of disclosure of my individually identifiable health information as described above. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment at the Practice is for the sole purpose of creating PHI for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

