BRAIN AND SPINE SURGERY, PC

Please print all information clearly. Thank You. Date: _____

Patient Name: _____ Social Security # : _____

Home Address: _____ Date of Birth: _____

_____ Martial Status: ____ Married ____Single ____Divorced

Home Telephone: _____ ____Widowed ____Minor

Work Telephone: _____ In Case of Emergency:

Alternate #: _____ Notify: _____

Employer: _____ Relationship: _____

Primary Care Physician: _____ PCP's Telephone #: _____

Referring Physician: _____ Referring MD's Telephone #: _____

Private Health Insurance Information

Primary Insurance: _____

Name of Policy Holder (if not patient): _____ D/O/B: _____

Insurance ID#: _____ Group#: _____

Secondary Insurance: _____

Name of Policy Holder (if not patient): _____ D/O/B: _____

Insurance ID#: _____ Group#: _____

Type of Case: ____Regular Insurance ____Workers' Compensation ____No Fault Date of Injury: _____

Do you need a referral to see a specialist? ____Yes __No Do you have a copayment/deductible? ____Yes ___No

Deductible Amount: $_____ Copayment Amount: $_____

Assignment of Benefits/Authorization for Release of Information

I request that payment of authorized Medicare or private insurance benefits be made for any covered services furnished to me by Magdy S. Shady, MD and/or J. Frederick Harrington, MD. I authorize any holder of medical information about me to release the Health Care Financing Administration and it's agents, Champus and it's agents, or to any private insurance company, any health information needed to determine these benefits or the benefits payable for related services. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for charges in a timely manner, or I fail to provide within thirty (30) days the information necessary to submit the claim for payment.

_____ _____

Signature of Patient (Parent/Guardian if patient is a minor) Date

_____ _____

Signature of Representative (if patient is unable to sign) Date

BRAIN AND SPINE SURGERY, PC

Please print all information clearly. Thank You. Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

PCP:_____ Referring MD: _____

Health Information / Please Check All that Apply

Drug Allergies (if none please indicate): _____

Medications (if none please indicate): _____

Hospitalizations: _____

Operations: _____

Please Check: ____ Right Handed ____Left Handed

____ Alcohol Use ____Drug Use ____Smoking ____Weight Loss

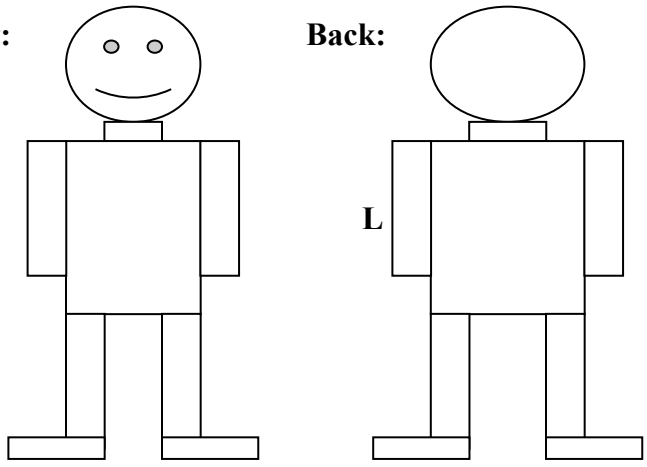
____ High Blood Pressure
____ Diabetes Mellitus
____ Stomach Ulcers
____ **Heart Disease**
____ Angina/Chest Pain
____ Heart Attack
____ Heart Surgery
____ Irregular Heart Beat
____ Heart Failure
____ Pace Maker
____ Valve Disease
____ **Respiratory Disease**
____ Emphysema
____ Asthma
____ Tuberculosis
____ Bronchitis
____ Sinusitis

____ **Blood Disorders**
____ Clotting Problems
____ Anemia
____ Immune Deficiency
____ **Liver Disease**
____ Hepatitis
____ Yellow Jaundice
____ **Kidney Disease**
____ Dialysis/Failure
____ Infection
____ **Endocrine Disease**
____ Thyroid Disease
____ Adrenal Disease
____ Pituitary Disease
____ **Arhtritis**
____ Rheumatoid Arthritis
____ Lupus

____ **Infectious Disease**
____ Tuberculosis
____ Lyme's Disease
____ **Neurological Disease**
____ Stroke
____ Epilepsy/Seizures
____ Parkinson's Disease
____ Multiple Sclerosis
____ Neurofibromatosis
____ Headache/Migraine
____ Urinary Problems
____ Walking Difficulties
____ Visual Problems
____ **Cancer**
____ **Malignant Hyperthermia**
____ Other: _____
_____

Please use the diagram below to indicate location of pain:

Front: **Back:**



Pain
Pain
Pain

_____Pain
_____Neck Pain
_____Arm
_____Back
_____Leg

BRAIN AND SPINE SURGERY, PC

2500 Nesconset Highway, Building 18C, Stony Brook, New York 11790
Telephone 631.751.2700 ~ Facsimile 631.751.5853

HIPPA PRIVACY AUTHORIZATION FORM

Authorization

I, _____, hereby authorize Brain and Spine Surgery, PC and its affiliates and employees to use and disclose the protected health information described below to:

Name(s) Contact Number(s) Relationship(s)

_____

_____

_____

Effective Period

This authorization for release of information covers the period of health care from (choose one):

_____ The period from _____ to _____

_____ All past, present and future periods

Extent of Authorization

This authorization for release of information covers the following (choose one):

_____ I authorize the release of my complete health record

_____ I authorize the release of my complete health record with the exception of the following information: _____

_____

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditional on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal or state law.

Signature: _____ Date: _____

Your Name (Printed): _____

BRAIN AND SPINE SURGERY, PC

2500 Nesconset Highway, Building 18C, Stony Brook, New York 11790
Telephone 631.751.2700 ~ Facsimile 631.751.5853

Magdy S. Shady, MD
Diplomate American Board of Neurological Surgery
Fellow of the American Association of Neurological Surgeons
Clinical Assistant Professor of Neurosurgery and Radiation Oncology

J. Frederick Harrington, MD
Diplomate American Board of Neurological Surgery
Fellow of the American Association of Neurological Surgeons

RECORDS RELEASE AUTHORIZATION AND CONSENT

I request and authorize you to release the complete medical history concerning my illness and/or treatment during the period from _____ to _____ to:

Brain and Spine Surgery, PC
2500 Nesconset Highway
Building 18C
Stony Brook, NY 11790
Fax # 631-751-5853

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Cell #: _____

Name at time of service, if different: _____

Patient Signature: _____ Date: _____

Signature of Representative (if patient is unable to sign): _____

BRAIN AND SPINE SURGERY, PC

WORKERS' COMPENSATION INFORMATION

PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____

Telephone: _____ SS#: _____

EMPLOYER INFORMATION (At time of accident)

Employer Name: _____

Employer Address: _____

Employer Telephone: _____ Contact Person: _____

Occupation: _____ Are you currently working? Yes_____No_____

If no, date of last employment: _____

WORKERS' COMPENSATION CARRIER

Name of Carrier: _____

Carrier Address: _____

Carrier Telephone: _____ Adjustor: _____

Carrier Case #: _____ WCB#: _____

INJURY INFORMATION

Date of Injury: _____ Time: _____ Place of Injury: _____

How did accident happen? _____

Is your case currently controverted? _____ Date of next hearing? _____

Have you had an IME (Independent Medical Exam)? Yes_____ No_____ (If so, when?_____)

Attorney Name & Address: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible in the event that my Workers' Compensation benefit in denied. I also authorize Dr. Shady and/or Dr. Harrington to bill my private health insurance coverage in the event my Workers' Compensation claim is denied or controverted.

Date: _____ Signature: _____