

BRAIN & SPINE SURGERY, P.C.

Please print all information clearly. Thank You.

Date: _____

Patient Name: _____ Social Security # : _____

Home Address: _____ Date of Birth: _____

_____ Marital 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. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents, Champus and its 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 Beneficiary (Parent/Guardian if patient is a minor)

Date

Signature of Representative (if patient is unable to sign)

Date

BRAIN & SPINE SURGERY, P.C.

Please print all information clearly. Thank You.

Date: _____

Patient Name: _____

Date of Birth: _____

Height: _____

Weight: _____

PCP: _____

Referring MD: _____

Pharmacy: _____

Pharmacy Tel#: _____

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

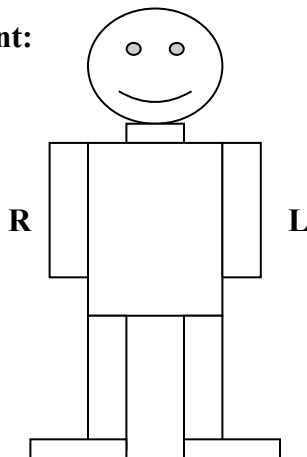
- High Blood Pressure
- Diabetes Mellitus
- Stomach Ulcers
- Heart Disease**
- Angina/Chest Pain
- Heart Attack
- Heart Surgery
- Irregular Heart Beat
- Heart Failure
- Pace Maker
- Valve Disease
- Respiratory Disease**
- Emphysema
- Asthma
- Tuberculosis
- Bronchitis
- Sinusitis

- 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
- Arthritis**
- Rheumatoid Arthritis
- Lupus

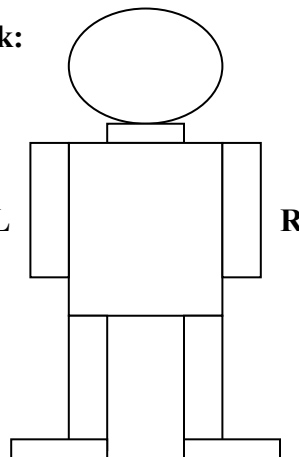
- Infectious Disease**
- Tuberculosis
- Lyme's Disease
- Neurological Disease**
- Stroke
- Epilepsy/Seizures
- Parkinson's Disease
- Multiple Sclerosis
- Neurofibromatosis
- Headache/Migraine
- Urinary Problems
- Walking Difficulties
- Visual Problems
- Cancer**
- Malignant Hyperthermia**
- Other: _____

Please use the diagram below to indicate location of pain:

Front:



Back:



- Pain**
- Neck Pain**
- Arm Pain**
- Back Pain**
- Leg Pain**

BRAIN & SPINE SURGERY, P.C.

2500 Nesconset Highway, Building 1, Stony Brook, New York 11790
Telephone 631.751.2700 ~ Facsimile 631.751.5853

HIPAA PRIVACY AUTHORIZATION FORM

Authorization

I, _____, hereby authorize Brain & 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 & SPINE SURGERY, P.C.

2500 Nesconset Highway, Building 1, Stony Brook, New York 11790
Telephone 631.751.2700 ~ Facsimile 631.751.5853

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 & Spine Surgery, PC
2500 Nesconset Highway
Building 1
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 & SPINE SURGERY, P.C.

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 is denied. I also authorize Dr. Shady to bill my private health insurance coverage in the event my Workers' Compensation claim is denied or controverted.

Date: _____ Signature: _____