



WELCOME TO NEW YORK SPINE SURGERY & REHABILITATION

Thank you for choosing New York Spine Surgery & Rehabilitation as your spinal treatment provider.

We greatly appreciate your time in **FULLY** completing the following assessment. This will give us thorough information about your condition and help us give you the best possible care.

Please be sure to provide all pertinent information concerning Worker's Compensation and auto accident related injuries, including:

- Social security number
- Compensation/No-Fault carrier's full company name and complete address
- Worker's Compensation: WCB#, Carrier Case # and Date of Injury
- Auto accident: Policy and Claim #'s.
- Telephone & fax number

If the above information is not available to you, please contact your insurance company to obtain this information. Keep in mind that if we do not have the correct information, our requests to Worker's Compensation for your diagnostic testing and/or treatment will be unable to be processed due to lack of information.

We greatly appreciate your cooperation.

New York Spine Surgery & Rehabilitation, PLLC
243 North Road, Suite 202 South
Poughkeepsie, NY 12601

Phone: 845-471-9200

Fax: 845-471-1551

Runner Present: _____ (Office Use Only)

Today's Date: ____/____/2008

Referring Physician /Patient: _____

PATIENT

Name (Print): _____ Your Age: _____ Birthdate: ____/____/____

Home Address: _____ Home Phone: ____ - ____ - ____

City: _____ State: _____ Zip Code: _____

Marital Status: _____ Occupation: _____

Social Security Number: _____ - _____ - _____

If you would like to receive your dictation by email please supply email address on the line below. Thank You.

Spouse's Name: _____ Occupation: _____

Business Address: _____ Business Phone: ____ - ____ - ____

City: _____ State: _____ Zip Code: _____

Patient's Employer: _____ Self Employed? Yes/ No

Business Address: _____ Business Phone: ____ - ____ - ____

City: _____ State: _____ Zip Code: _____

Name and Address of person to be billed: _____

City: _____ State: _____ Zip Code: _____

Name of nearest relative not living with you: _____ **Phone:** _____

Name Of Person to Contact in an Emergency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ____ - ____ - ____ Fax: ____ - ____ - ____

Please List Insurance Coverage:

Primary: _____ ID Number: _____

Address: _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Secondary: _____ Number: _____

Credit Card Number: _____

Compensation Case? _____ Auto Accident? _____ Registration State: _____ Date of Accident: ____/____/____

Comp or Auto Insurance Carrier: _____ Carrier Case#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ - _____ - _____ Fax: _____ - _____ - _____

FINANCIAL POLICY: PLEASE READ CAREFULLY AND THOROUGHLY

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information on this sheet and have complete all of the answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature _____ Date _____

PAYMENT IN FULL IS EXPECTED FOR SERVICES AT THE TIME THEY ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. THIS INCLUDES ALL COPAYMENTS, COINSURANCE, AND DEDUCTIBLES. IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. WE WILL GLADLY BILL YOUR INSURANCE COMPANY FOR YOU SO THAT YOU ARE REIMBURSED.

PLEASE BE AWARE THAT NO MATTER WHAT THE CIRCUMSTANCES ARE CONCERNING YOUR ACCOUNT, IF A BALANCE EXISTS YOU WILL ALWAYS RECEIVE A MONTHLY STATEMENT OF YOUR ACCOUNT. THIS WILL KEEP YOU CONSTANTLY AWARE OF THE STATUS SHOULD IT BE NECESSARY FOR YOU TO CONTACT YOUR INSURANCE COMPANY FOR NON-PAYMENT.

I UNDERSTAND THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF FOR ANY REASON MY INSURANCE COMPANY DENIES PAYMENT, I AM FULLY RESPONSIBLE FOR ANY SERVICES RENDERED. I ALSO AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO MY INSURANCE COMPANY, SHOULD IT BE NECESSARY, IN ORDER TO PROCESS ANY OF MY MEDICAL CLAIMS.

Signature: _____ Date: ____/____/____

Patient Name: _____
Employer: _____
Insurance Name: _____
SS#/ID#: _____

Date: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

New York Spine Surgery & Rehabilitation Medicine, PLLC
243 North Road, Suite 202S
Poughkeepsie, New York 12601

OR

If my current policy prohibits direct payment to the Doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

New York Spine Surgery & Rehabilitation Medicine, PLLC
243 North Road, Suite 202S
Poughkeepsie, New York 12601

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above be this insurance payment.

A photocopy of this Assignment of Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjusted, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at New York Spine Surgery & Rehabilitation Medicine, PLLC: ____/____/2008

Signature of Policyholder

Witness

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to NEW YORK SPINE SURGERY & REHABILITATION MEDICINE, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)

(Signature of Patient)

(Date of signature)

(Address of Patient)

NEW YORK SPINE SURGERY &
REHABILITATION MEDICINE

(Print name of Provider)

(Signature of Provider)

243 NORTH RD. STE. 202S

(Date of signature)

POUGHKEEPSIE, NY 12601

(Address of Provider)

New York Spine Surgery & Rehabilitation, PLLC
243 North Road, Suite 202 South
Poughkeepsie, NY 12601

Phone: 845-471-9200

Fax: 845-471-1551

RELEASE OF MEDICAL INFORMATION TO OTHER PHYSICIANS:

FROM TIME TO TIME, IT MAY BE NECESSARY FOR YOUR DOCTOR TO SHARE MEDICAL INFORMATION WITH OTHER PHYSICIANS (SUCH AS YOUR FAMILY DOCTOR OR PRIMARY CARE PHYSICIAN) WHO MAY BE CURRENTLY INVOLVED IN YOUR TREATMENT. THIS ALLOWS THE DOCTOR TO CROSS REFERENCE IMPORTANT MEDICAL INFORMATION AND AIDS YOU IN PROVIDING WITH THE BEST CARE POSSIBLE. YOUR DOCTOR CAN ONLY SHARE YOUR MEDICAL RECORDS WITH OTHER PHYSICIANS WHEN YOU RELEASE HIM/HER TO DO SO. BY COMPLETING YOUR SIGNATURE BELOW, YOU UNDERSTAND ALL OF THE ABOVE AND ALLOW THIS OFFICE TO SHARE MEDICAL INFORMATION NECESSARY FOR YOUR TREATMENT.

Signature: _____ Date: _____/_____/_____

Research Consent:

_____ I agree to and hereby permit information available in this medical record to be used for scientific investigations so long as I am not personally identified.

_____ I do not agree to permit information available in this medical record to be used for scientific investigations.

Signature: _____

Date: _____ / _____ / _____

Witness: _____

Date: _____ / _____ / _____

Disability: If you have been incapacitated and unable to work, please give dates of disability:

From: _____ To: _____

Marital Status:

Choose One: Married _____; Single _____; Widow _____; Divorced _____

If You Are A Minor, Name of Parents: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ - _____ - _____

Fax: _____ - _____ - _____

CLINICAL INFORMATION:

List in order of importance your **main complaints**:

1)

2)

3)

4)

When did the problem start?

How did this problem start?

Describe the pain (include location):

On a scale of 1-10, with **0 being no pain** and 10 being extremely severe, how would you rate your pain now?

Neck _____ Right Arm _____ Left Arm _____ Back _____ Right Leg _____ Left Leg _____

Did your back/neck pain get better once the leg/arm pain started? _____

Is your back/neck pain: Constant _____ Intermittent _____

Is your back/neck pain: Getting Better _____ The Same _____ Getting Worse _____

Do you have numbness? (if yes, where?)

Do you experience pins and needles (if yes, where?)

Do you have weakness in your legs or arms? (If yes, where?).

Do you have problems with your bowel or bladder?

How much time during your usual waking hours do you spend lying down?

Does bending / lifting / twisting / reaching / coughing or sneezing bother you?

Do you have night pain?

How are you with:

1) walking?

2) standing?

3) sitting?

4) driving?

5) sleeping?

6) working?

Is your balance normal/abnormal?

What do you do for recreation?

What do you do socially?

What activities of daily living are you involved in (e.g. cooking, mowing the lawn, etc.)

Detail your treatments to date in chronological order: Include the **names, dates** and **locations** of treatments
PLEASE INCLUDE DATES OF TREATMENT:

Physiatrist: _____

Family MD/
Internist/GP: _____

Chiropractor: _____

Neurologist: _____

Orthopaedic
Surgeon: _____

Neurosurgeon: _____

Pain Specialist: _____

Have You Been Treated With Epidural Steroid Injections: Yes / No

Other Specialists:

Detail your overall progress to date: _____

Previous Medical History: (Such as diabetes, high blood pressure, rheumatic fever etc.):

Previous Spinal Surgery: Please note the procedure done, name of surgeon, institution and results:

Previous Surgical History: Please note ALL previous surgeries and dates that they were done:

What medications do you take: List all (with dosage, frequency, duration, and prescriber)

Medication Name	Dosage	Frequency	How long have you taken this medication?	Prescribed by?

What medications are you allergic to:

Allergy to:	Type of Reaction:	Allergy to:	Type of Reaction:

Do you smoke?

If yes, how much?

Do you drink?

If yes, how much?

How tall are you: _____ inches; How much do you weigh? _____ pounds

These Questions Pertain To YOUR NECK & UPPER EXTREMITIES only:

CERVICAL SPINE:

On the average, how would you rate the pain **in the neck** that you are having?

Choose one: None = 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 = severe

On the average, how would you rate the pain in the **right upper extremity** that you are having?

Choose one: None = 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 = severe

On the average, how would you rate the pain **left upper extremity** that you are having?

Choose one: None = 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 = severe

Severity of Symptoms

On the average In the last month how would you describe:

The pain that you had including **pain in your neck, and pain that goes through your upper extremities:**

Choose one : none / mild / moderate / severe / very severe

The **pain in your neck:**

Choose one : none / mild / moderate / severe / very severe

The **pain in upper extremities:**

Choose one : none / mild / moderate / severe / very severe

Numbness and tingling in your upper extremities:

Choose one : none / mild / moderate / severe / very severe

Weakness in your upper extremities:

Choose one : none / mild / moderate / severe / very severe

How often have you had neck or upper extremity pain?

Choose one : less than once a week / at least once a week / everyday, for at least a few minutes
everyday most of the day / every minute of the day

Do you have problems with your balance?

Choose one: never/ sometimes / often

In the last month on a typical day: **How far have you been able to walk**

less than 1 New York City block

greater than 1 block and less than 2 blocks

greater than 2 blocks and less than 10 blocks

greater than 10 blocks and less than 20 blocks

greater than 20 blocks: list number blocks _____; list number of miles _____

Have you taken **walks outdoors or in the malls for pleasure?**

Choose one: no, this is not possible / yes, but always with pain / yes, but sometimes with pain / yes, comfortably

Have you been **shopping for groceries or other items?**

Choose one: no, this is not possible / yes, but always with pain / yes, but sometimes with pain / yes, comfortably

Have you **walked around the different rooms in your house / apartment?**

Choose one: no, this is not possible / yes, but always with pain / yes, but sometimes with pain / yes, comfortably

Have you **walked from your bedroom to your bathroom?**

Choose one: no, this is not possible / yes, but always with pain / yes, but sometimes with pain / yes, comfortably

These Questions Pertain To YOUR LOWER BACK & LOWER EXTREMITIES only:

LUMBAR SPINE:

On the average, how would you rate the pain **in the back** that you are having?

Choose one: None = 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 = severe

On the average, how would you rate the pain in the **right lower extremity** that you are having?

Choose one: None = 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 = severe

On the average, how would you rate the pain **left lower extremity** that you are having?

Choose one: None = 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 = severe

Severity of Symptoms

On the average In the last month how would you describe:

The pain that you had including **pain in your back, buttocks and pain that goes down your leg:**

Choose one : none / mild / moderate / severe / very severe

The **pain in your back or buttocks:**

Choose one : none / mild / moderate / severe / very severe

The **pain in your legs or feet**

Choose one : none / mild / moderate / severe / very severe

Numbness and tingling in your legs or feet:

Choose one : none / mild / moderate / severe / very severe

Weakness in your legs or feet:

Choose one : none / mild / moderate / severe / very severe

How often have you had back, buttock or leg pain?

Choose one : less than once a week / at least once a week / everyday, for at least a few minutes
everyday most of the day / every minute of the day

Do you have problems with your balance?

Choose one: never/ sometimes / often

In the last month on a typical day: **How far have you been able to walk**

less than 1 New York City block

greater than 1 block and less than 2 blocks

greater than 2 blocks and less than 10 blocks

greater than 10 blocks and less than 20 blocks

greater than 20 blocks: list number blocks _____; list number of miles _____

Have you taken **walks outdoors or in the malls for pleasure?**

Choose one: no, this is not possible / yes, but always with pain / yes, but sometimes with pain / yes, comfortably

Have you been **shopping for groceries or other items?**

Choose one: no, this is not possible / yes, but always with pain / yes, but sometimes with pain / yes, comfortably

Have you **walked around the different rooms in your house / apartment?**

Choose one: no, this is not possible / yes, but always with pain / yes, but sometimes with pain / yes, comfortably

Have you **walked from your bedroom to your bathroom?**

Choose one: no, this is not possible / yes, but always with pain / yes, but sometimes with pain / yes, comfortably

Review of Systems:

Do you have any complaints with reference to your:

Head/Neurological	Heart/ Lungs	Kidneys
Neck	Appetite	Urine
Eyes	Bowels	Stomach
Other		

Do you have any problems with your

Hips	Knees	Ankles
Shoulders	Elbows	Wrists

Ears, Nose, Throat

FEMALES: THE FOLLOWING QUESTIONS ARE IMPORTANT BECAUSE WE DO NOT WISH TO DO XRAYS OR IMAGING STUDIES IF YOU ARE PREGNANT OR IF THERE IS A CHANCE THAT YOU ARE PREGNANT

Date of last menstrual period:

Date of menopause:

Is there a chance that you may be pregnant?

Do you take oral contraceptives?

Did you have a hysterectomy?

Family History:

	<u>Yes</u>	<u>No</u>
Diabetes:	_____	_____
Rheumatoid Arthritis:	_____	_____
Muscle/Nerve Disorder:	_____	_____
Spinal Disorders:	_____	_____
Other:	_____	_____

Circle **tests done**, with approximate date:

X-Rays: 1) Date: _____ / _____ / _____ 2) Date: _____ / _____ / _____

MRI: 1) Date: _____ / _____ / _____ 2) Date: _____ / _____ / _____

CT: 1) Date: _____ / _____ / _____ 2) Date: _____ / _____ / _____

EMG: 1) Date: _____ / _____ / _____ 2) Date: _____ / _____ / _____

Bone Scan: 1) Date: _____ / _____ / _____ 2) Date: _____ / _____ / _____

Other: 1) Date: _____ / _____ / _____ 2) Date: _____ / _____ / _____

FOR DOCTOR USE ONLY

PHYSICAL EXAMINATION:

REFLEXES	Right	Left
Biceps		
Brachoradialis		
Triceps		
Knee		
Ankle		

	Right	Left
Hoffman		
Clonus		
Babinski		
Pulses		

SENSATION	Right	Left
C5		
C6		
C7		
C8		
T1		
L2		
L3		
L4		
L5		
S1		

Motor Power	Right	Left
C5		
C6		
C7		
C8		
T1		
L2		
L3		
L4		
L5		
S1		

	Right	Left
SLR		
Bowstring		
Femoral N. Stretch		
Hips		

Gait:

- C-HNP T-HNP L-HNP C-DDD T-DDD L-DDD
 C-SS T-SS L-SS
 Spondylolisthesis Scoliosis

FOR DOCTOR USE ONLY

Diagnosis:

Plan:

Tests:

X-Rays:

MRI:

CT-Myelogram:

EMG:

Bone Scan:

Other:

Conservative:

___ Nsaids

___ Medrol dosage pack

___ Modalities

___ Ultrasound with topical phonophoresis:

___ Strengthening / ROM

___ Physical therapy:

___ Brace

___ Pain Management

Surgical:

___ Decompression

___ Decompression Fusion

___ Decompression Fusion Instrumentation

___ Other: