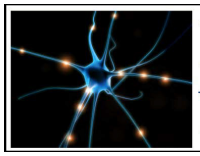
DIF



FIVE TOWNS NEUROLOGY

923 Broadway
Woodmere, NY 11598
516 239 1800
Fax: 516 295 5557

DEMOGRAPHIC INTAKE FORM

Tell Us About Yourself

Today's Date:____/____/____

Last Name:_____ MI:___

First Name:_____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Cell: _____ Work: _____

Primary Doc: _____ Phone: _____

Referr Doc: _____ Phone: _____

DOB: ___/___/___ Male of Female (circle one)

Married-Divorced-Single-Widowed (circle one)

Social Security #: _____ - ____ - _____

Working-Disabled-Retired-Unemployed (circle)

Employer Name: _____

Student? (Y or N?) - If Yes, FT/PT? (circle one)

Your Insurance Info

Do You Have Insurance Coverage? Y or N

Are You the Primary Insured? Y or N

If Not, Name & Relation:_____

Their Address: _____

Their Phone:_____

Ins Comp: _____ Policy#:_____

Group#:_____

In An Emergency

Emergency Contact (EC):_____

EC: Spouse-Child-Parent-Sibling-Friend (circle)

EC First N: _____ EC Last N: _____

EC Address Same as Primary? Y or N

If Not, EC Address:_____

EC City: _____ EC State:_____

EC Zip Code: _____

Additional Demographic Information

Do You Have Any Secondary Ins? Y or N? If Yes, Name & Primary Insured:_____

Is there any chance your presentation today is related to any personal injury including car accident, work accident or slip & fall/liability injury? Y or N?

Do You Have an Email Address? Y or N? If Yes, Email Address:_____

Name of Primary Pharmacy:_____ Pharmacy Address:_____

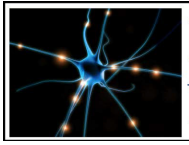
Pharmacy City/State:_____ Pharmacy Phone:_____

White-Black-Asian-Hispanic-Other:_____ English-Spanish-Other:_____

I hereby authorize payment of medical benefits billed to my insurance to Five Towns Neurology PC. I hereby accept responsibility for payment for any service(s) provided to me that are NOT covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the practice does not participate with my insurance. I agree to pay all copayments, coinsurances and deductibes at the time of service(s) are rendered. (Note many insurance plans have high deductibles for standard care that our practice has no way to be aware of.)

Signature of Patient or Patient Representative: _____ ***Date:*** _____/_____/_____

CRI-MIHR



FIVE TOWNS NEUROLOGY

David Steiner MD - Sandra Chandipersaud, PA-C - Marco Benitez PA-C - David Salib DPT
923 Broadway, Woodmere, NY 11598 516 239 1800 - Fax: 516 295 5557

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby authorize FIVE TOWNS NEUROLOGY, PC to use and/or disclose my health information which speciically identifies me or that which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I undestand that while this consent is voluntary, if I refuse to sign, FIVE TOWNS NEUROLOGY PC can decline to treat me.

I have been infomed that FIVE TOWNS NEUROLOGY PC has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and healthcare operations. I understand that I have the right to review such Notice prior to signing the consent.

I understand that I may revoke this consent at any time by notifying FIVE TOWNS NEUROLOGY PC in writing, but should I do so, such revocation will not affect any actions that FIVE TOWNS NEUROLOGY PC took before receiving my revocation.

I understand that FIVE TOWNS NEUROLOGY PC has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that FIVE TOWNS NEUROLOGY PC restrict the manner in which my indiviually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that FIVE TOWNS NEUROLOGY PC does not have to agree to such restrictions, but that once such restrictions are agreed to, FIVE TOWNS NEUROLOGY PC must adhere to such restrictions.

Patient or Representative signature: _____ Date: ____/____/____

Printed Name of Patient or Represenative: _____ If Representative, relationship: _____

MEDICAL INFORMATION/HIPAA RELEASE

Release of Information

Name: _____ Date of Birth: ____/____/____

❑ I authorize the release of information including the diagnoiss, records, examination rendered to me and claims information. This may be released to:

- ❑ Spouse: _____
- ❑ Child(ren): _____
- ❑ Other: _____

❑ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ❑ My Home ❑ My Work ❑ My Cellphone Number: _____
If unable to reach me:
❑ You may leave a detailed message ❑ Other: _____
❑ Please leave a message asking me to return your call

The best time to reach me is: (day): _____ between (best time): _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

IPMI-1

FIVE TOWNS NEUROLOGY
923 Broadway, Woodmere, NY 11516 516 239 1800 Fax: 516 295 5557

INITIAL PATIENT MEDICAL INTAKE

Patient Name: _____ **Today's Date: _____** **DOB: _____**

Reason for Today's Visit: _____

SYMPTOMS

Check (✓) Conditions You Currently Have or Have Had in the Past Year

CONSTITUTIONAL:
☐ ***None of the Following Apply to Me***
☐ Fatigue ☐ Fever ☐ Loss of Appetite ☐ Night Sweats
☐ Weakness ☐ Weight Loss ☐ Weight Gain

ALLERGY/IMMUNE:
☐ ***None of the Following Apply to Me***
☐ Colds ☐ Ear Fullness ☐ Hives ☐ Itchy Eyes
☐ Nasal/Seasonal Allergies ☐ Nighttime Nasal Allergies
☐ Recurrent Infections ☐ Runny Nose
☐ Scratchy Throat ☐ Sinus Congestion ☐ Stuffy Nose
☐ Swollen Glands

OPHTHALMOLOGY:
☐ ***None of the Following Apply to Me***
☐ Blurred Vision ☐ Cataracts ☐ Diminished Vision
☐ Discharge ☐ Double Vision ☐ Eye Irritation
☐ Loss of Vision ☐ Eye Pain ☐ Seasonal Symptoms
☐ Visual Changes ☐ Watery Eyes

ENT/RESPIRATORY:
☐ ***None of the Following Apply to Me***
☐ Change in Voice ☐ Chronic Cough ☐ Cold
☐ Coughing up Blood ☐ Difficulty Swallowing
☐ Dizziness ☐ Drooling ☐ Frequent Nasal Allergies
☐ Frequent Nosebleed ☐ Hearing Loss
☐ Nighttime Congestion ☐ Orthopnea
☐ Pain with Breathing ☐ Ringing in Ears
☐ Shortness of Breath ☐ Sinus Problems
☐ Sore Throat ☐ Trouble Breathing Through Nose

ENDOCRINOLOGY:
☐ ***None of the Following Apply to Me***
☐ Cold Intolerance ☐ Diabetes ☐ Excessive Sweating
☐ Excessive Thirst ☐ Fatigue ☐ Heat Intolerance
☐ Hot Flashes ☐ Sexual Dysfunction
☐ Frequent Urination

CARDIOLOGY:
☐ ***None of the Following Apply to Me***
☐ Chest Pain ☐ Chest Pain While Asleep ☐ Chest Pain While Awake ☐ Dizziness ☐ Irregular Heart Beat
☐ Leg Swelling ☐ Pain in Leg While Walking
☐ Palpitations ☐ Shortness of Breath ☐ Varicose Veins

GASTROENTEROLOGY:
☐ ***None of the Following Apply to Me***
☐ Abdominal Pain ☐ Blood in Stool
☐ Change in Bowel Habits ☐ Constipation ☐ Diarrhea
☐ Difficult Swallowing ☐ Frequent Bloating
☐ Heartburn ☐ Indigestion ☐ Nausea ☐ Vomiting
☐ Vomiting Blood

HEMATOLOGY:
☐ ***None of the Following Apply to Me***
☐ Blood Transfusion ☐ Easy Bruising ☐ Fatigue
☐ Loss of Appetite ☐ Swollen Glands
☐ Varicose Veins

GENITOURINARY FEMALE:
☐ ***None of the Following Apply to Me***
☐ Blood in Urine ☐ Difficulty Urinating
☐ Dysmenorrhea ☐ Frequent Nighttime Urination
☐ Hot Flashes ☐ Irregular Periods ☐ Lactation
☐ Sexually Active ☐ Still Menstruating
☐ Vaginal Discharge

GENITOURINARY MALE:
☐ ***None of the Following Apply to Me***
☐ Blood in Urine ☐ Difficulty Urinating
☐ Difficulty with Erection
☐ Frequent Nighttime Urination
☐ Impotence ☐ Sexually Active
☐ Testicular Pain or Swelling
☐ Urinary incontinence

MUSCULOSKELETAL:
☐ ***None of the Following Apply to Me***
☐ Neck Pain ☐ Middle Back Pain ☐ Low Back Pain
☐ Joint Pain ☐ Joint Stiffness ☐ Joint Swelling ☐ Leg Cramps ☐ Shooting Arm Pain ☐ Shooting Leg Pain
☐ Arm Numbness/Tingling ☐ Leg Numbness/Tingling

DERMATOLOGY:
☐ ***None of the Following Apply to Me***
☐ Dry or Sensitive Skin ☐ Hives ☐ Lumps ☐ Rash

UROLOGY:
☐ ***None of the Following Apply to Me***
☐ Blood in urine ☐ Difficulty Urinating
☐ Erectile or Other Sexual Dysfunction ☐ Nocturia
☐ Recurrent Urinary Tract Infection
☐ Voiding Dysfunction

NEUROLOGY
☐ ***None of the Following Apply to Me***
☐ Balance Difficulty ☐ Dizziness ☐ Fainting Spells
☐ Falls ☐ Gait Abnormality ☐ Headache
☐ Loss of Sensation in Specific Body Area
☐ Loss of Strength in Specific Body Area ☐ Numbness
☐ Memory problems ☐ Pain ☐ Seizure ☐ Tingling
☐ Tremors ☐ Trouble with Balance
☐ Trouble with Coordination

PSYCHOLOGY
☐ ***None of the Following Apply to Me***
☐ Anxiety ☐ Attention deficit ☐ Depression
☐ Eating Disorder ☐ Hallucinations ☐ Hyperactivity
☐ Irritability ☐ Mental or Physical Abuse
☐ Nightmares ☐ Sleep Disturbance ☐ Suicidal Thoughts
☐ Tension/Stress

CONDITIONS

Check (✓) Conditions you Currently Have or Have Had in the Past Year

☐ AIDS ☐ Alcoholism ☐ Anemia ☐ Anorexia ☐ Appendicitis ☐ Arthritis ☐ Bleeding Disorders ☐ Breast Lump ☐ Bronchitis ☐ Bulimia ☐ Cancer ☐ Cataracts ☐ Chemical Dependency ☐ Chicken Pox ☐ Diabetes ☐ Emphysema ☐ Epilepsy ☐ Glaucoma ☐ Goiter ☐ Gonorrhea ☐ Gout ☐ Heart Disease ☐ Hepatitis ☐ Hernia ☐ Herpes ☐ High Cholesterol ☐ HIV Positive ☐ Kidney Disease ☐ Liver Disease ☐ Measles ☐ Migraine ☐ Miscarriage ☐ Mononucleosis ☐ Multiple Sclerosis ☐ Mumps ☐ Pacemaker ☐ Pneumonia ☐ Polio ☐ Prostate Problem ☐ Psychiatric Care ☐ Rheumatic Fever ☐ Scarlet Fever ☐ Stroke ☐ Suicide Attempt ☐ Thyroid Problems ☐ Tonsillitis ☐ Tuberculosis ☐ Typhoid Fever ☐ Ulcers ☐ Vaginal Infections ☐ Venereal Disease

MEDICATIONS

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Please List Medications You are Currently Taking

ALLERGIES

_____
_____
_____
_____

FIVE TOWNS NEUROLOGY
923 Broadway
Woodmere NY 11598
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IPMI-2

FAMILY HISTORY

Fill in Health Information About Your Family

Relation	Age	State of Health	Age of Death	Cause of Death	Check (✓) if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have You Ever Had a Blood Transfusion? ☐ Yes ☐ No

If Yes, Please Give Approximate Dates: _____

Serious Illness/Injuries	Date	Outcome

PREGNANCIES

Year of Birth	Sex of Birth	Complications if Any

HEALTH HABITS

Check (✓) Which Substances You Use and Describe How Much You Use:

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL

Check (✓) if Your Work Exposes You to Any of the Following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

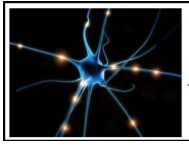
_____ _____

Signature Date

_____ _____

Reviewed By Date

ARMMR



FIVE TOWNS NEUROLOGY

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923 Broadway, Woodmere, NY 11598 516 239 1800 - Fax: 516 295 5557

AUTHORIZATION TO REQUEST MY MEDICAL RECORDS

Patient Name: _____

Address: _____

Contact Phone: _____ DOB: ____/____/____

Please request my medical records from the following Sources:

1. Name: _____

   Type: ❑ Physician ❑ Hospital ❑ Lawyer ❑ Rehab/PT Facility ❑ Other: _____

   Address:_____ City: _____ State: ____ Zip: _____

   Phone:_____ Fax:_____ Info to release: ❑ Notes ❑ Tests ❑ All Records

2. Name: _____

   Type: ❑ Physician ❑ Hospital ❑ Lawyer ❑ Rehab/PT Facility ❑ Other: _____

   Address:_____ City: _____ State: ____ Zip: _____

   Phone:_____ Fax:_____ Info to release: ❑ Notes ❑ Tests ❑ All Records

3. Name: _____

   Type: ❑ Physician ❑ Hospital ❑ Lawyer ❑ Rehab/PT Facility ❑ Other: _____

   Address:_____ City: _____ State: ____ Zip: _____

   Phone:_____ Fax:_____ Info to release: ❑ Notes ❑ Tests ❑ All Records

I hereby authorize the disclosure of my medical records as described above. I understand that this authorization is voluntary. Any health information disclosed pursuant to this authorization may be subject to redisclosure by the recipients and may no longer be protected by the Federal Privacy Regulations.

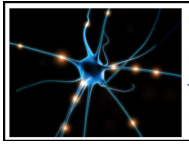
I understand that this authorization will expire in (1) year.

I understand that I may revoke this authorization at any time by notifying the above facility in writing. Revocation will not apply to information previously released or received.

Patient or Representative signature: _____ Date: ____/____/____

Printed Name of Patient or Represenative: _____ If Rep, relationship: _____

PRD



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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alterantive means, such as sending correspondence to the individual's office instead of the individual's home.

I Wish to be Contacted in the Following Manner (Check All That Apply):

❑ Cellphone
- ❑ Okay to Leave Detailed Message
- ❑ Only Leave Callback Number

❑ Home Phone
- ❑ Okay to Leave Detailed Message
- ❑ Only Leave Callback Number

❑ Work Phone
- ❑ Okay to Leave Detailed Message
- ❑ Only Leave Callback Number

❑ Written Communication
- ❑ Okay to Mail to My Home Address
- ❑ Okay to Mail to My Work/Office Addr
- ❑ Okay to Fax to: _____

Patient or Representative Signature: _____ Date: ____/____/____

Printed Name of Patient or Represenative: _____ If Rep, Relationship: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

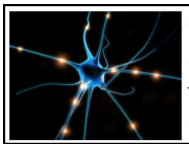
Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax #	(1)	Description/Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check Box if Disclosure Authorized **(3) How Disclosure Was Made; F=Fax; P=Phone; E=Email; M=Mail, O=Other**

(2) Type key: T=Treatment Records P=Payment Info O=Healthcare Oper A= Auth on File D=Discretionary

ESS



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THE EPWORTH SLEEPINESS SCALE

- ***The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness.***
- ***The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0 (no chance of dozing off) to 3 (high chance of dozing).***
- ***When you finish the test, add up the values of your responses.***
- ***Your total score is based on a scale of 0 to 24.***
- ***The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.***

How Sleepy Are You?

- How likely are you to doze off or fall asleep in the following situations?
- You should rate your chances of dozing off, not just feeling tired.
- Even if you have not done some of these things recently try to determine how they would have affected you if you were to do them.
- For each situation, decide whether or not you would have:

> No chance of dozing = 0

> Slight chance of dozing = 1

> Moderate chance of dozing = 2

> High chance of dozing = 3

Situation	Chance of Dozing
Sitting and reading	
Waching TV	
Sitting inactive in a public space (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon without a break	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE =	

Score Analysis

0-7: Within normal range
8-9: Average amount of daytime sleepiness
10-15: Possible excessive sleepiness
16-24: Strongly suggestive of excessive sleepiness

Original Source: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991; 14(6): 540-5.